Supreme Court, U. S.
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APR 9 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1447

STEPHEN BERGER, individually and as Commissioner of the Department of Social Services of the State of New York,

Petitioner,

against

MARION AITCHISON, individually and on behalf of MICHAEL AITCHISON, and JANICE AITCHISON, her children, and on behalf of all other persons similarly situated,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The Commissioner of the New York State Department of Social Services prays that a writ of certiorari issue to review the Jugment of the United States Court of Appeals for the Second Circuit, dated February 13, 1976, affrming, on the opinion below, an Order and Judgment of the United States District Court for the Southern District of New York, dated December 3, 1975. The District Court Order and Judgment declared invalid and enjoined New York Social Services Law § 366(2)(a)(8) and related state regulations, 18 NYCRR §§ 360.5(e) and 360.7 (a)(5), as inconsistent with 45 C.F.R. § 248.3(c)(1)(ii) to

the extent that the state provisions result in certain medical assistance recipients retaining less exempt income than is paid to categorical (AFDC) public assistance families of the same size, living in the same social services district and incurring the same costs for shelter and fuel.

The Court of Appeals stayed the issuance of its mandate pending the filing of this Petition. An application to this Court for a stay pending the disposition of the issues presented in the Petition will be filed with the Petition.*

Opinions Below

There is no opinion from the Court of Appeals. The Judgment of the Court of Appeals is reproduced in Appendix A, pp. 1a-2a, to this Petition. The opinion of the District Court is reported at 404 F. Supp. 1137 and is reproduced in Appendix B, pp. 3a-22a.

Jurisdiction

The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

The judgment of the Court of Appeals was entered on February 13, 1976.

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* The stay issued by the Court of Appeals on March 24, 1976 states that petitioner's motion of "March 4, 1976 to stay issuance of the mandate pending application to the Supreme Court of the United States for a writ of certiorari . . . is granted." The affidavit in support of the motion contained an undertaking that the Petition would be filed on or before March 31, 1976. Although the Court of Appeals did not incorporate the March 31 date in the stay and the Petition has been filed expeditiously, petitioner's attorney and respondents' attorney agreed to consider the Court of Appeals stay expired as of March 31 and to deduct the business days between that date and the date of the filing hereof from the seventy-five day compliance period allowed petitioner under the District Court Order and Judgment as modified. See Appendix D, pp. 26-28.

Question Presented

Whether New York's adoption of uniform levels of exempt income for medical assistance receipents based in part on averaged shelter cost with the result that some medical assistance recipients retain less exempt income than they would be paid as categorical (AFDC) public assistance recipients violates 45 C.F.R. § 248.3(c)(1) which generally requires that medical assistance exempt income levels be uniform within recipient groups of the same size and that they be expressed in "total dollar amounts" at the "higher of the levels of the payments standards generally used" in categorical assistance programs?

State Statute Involved

New York Social Services Law § 366 states in part:

Eligibility

• • •

2. (a) The following income and resources shall be exempt and shall neither be taken into consideration nor required to be applied toward the payment or part payment of the cost of medical care and services available under this title; provided, however, that such income may be required to be applied toward the enrollment fee, as required by subdivision five of section three hundred sixty-seven-a of this title.

• • •

(8)(i) Income in an amount set forth in the following schedules:

Annual net income—Number of family members in a household and family members for whom they are legally responsible or have assumed responsibility.

One	Two	Three	Four	Five	Six	Seven
$2,700	$3,800	$4,000	$5,000	$5,700	$6,400	$7,200[*]

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[*] This schedule was effective July 1, 1975.

Such income exemption shall be increased by six hundred dollars for each member of a family household in excess of seven.

(ii) on and after October first, nineteen hundred seventy-five, income in an amount set forth in the following schedule:

Annual net income—Number of family members in a household and family members for whom they are legally responsible or have assumed responsibility.

One	Two	Three	Four	Five	Six	Seven
$2,700	$3,800	$4,200	$5,000	$5,800	$6,500	$7,400

Such income exemptions shall be increased by seven hundred dollars for each member of a family household in excess of seven.

State Regulations Involved

18 Codes, Rules and Regulations § 360.5, states in part:

Determination of net available income and utilization of any excess

* * *

(e) If an applicant or recipient is receiving chronic care in a medical institution, or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for such applicant or recipient and the other members of his former family household. For the purpose of this subdivision and subparagraph (8) of paragraph (a) of subdivision 2 of section 366 of the Social Services Law, when a person is in chronic care, he shall not be deemed to be a member of any household except he

shall be considered a member of his former family household for the purpose of determining the amount of the savings exemption for such family household. The income of such applicant or recipient shall be utilized in the following order:

(1) to meet the maintenance needs of the dependent members of his former family household, less any amount of income in cash or in kind possessed by such dependent members, in accordance with the following schedules:

Numbers of Family Members in Household Dependent on Income

One	Two	Three	Four	Five	Six	Seven
$2,700*	$3,800*	$4,200**	$5,000	$5,800**	$6,500**	$7,400**

For each additional person in excess of seven in the household, add $700.00.

(2) the balance, if any, to meet the cost of his medical assistance.

18 Codes, Rules and Regulations § 360.7 states in part:

Legally responsible relatives living apart from dependent relatives [*]

The ability of a spouse living apart from dependent relatives to contribute toward the cost of care of his or her spouse and of a parent living apart from dependent relatives to contribute toward the cost of care

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* Effective July 1, 1975.

** Effective October 1, 1975.

[*] This section is being revised to conform with NYSSL § 366 (2) (a) (8), as amended by chapters 480 and 481 of the Laws of 1975. The relevant portions of the statute as amended are set forth at pp. 3-4, *ante*.

of his dependent child shall be ascertained as follows:

(a) The following income and resources shall be exempt and shall constitute a reserve for the legally responsible relative and members of his family household:

(1) a homestead which is essential and appropriate to the needs of the household;

(2) essential personal property;

(3) liquid resources in the amount of $500 for each member of the family household but not in excess of $2000 per family as a burial reserve;

(4) savings in amounts equal to at least one-half of the appropriate income reserve; and

(5) income in an amount set forth in the following schedule:

ANNUAL NET INCOME—MINIMUM RESERVE FOR MAINTAINING OF FAMILY HOUSEHOLD OF LEGALLY RESPONSIBLE RELATIVES LIVING APART FROM APPLICANT OR RECIPIENT

Number of Family Members in Household Dependent on Income

One	Two	Three	Four	Five	Six	Seven
$2,500	$3,400	$4,000	$5,000	$5,700	$6,400	$7,200

Such minimum reserve shall be increased by $600 for each member of a family household in excess of seven, who is dependent upon the income of such members.

Federal Regulation Involved

45 C.F.R. § 248.3 (1974 ed) states in part:

(c) With respect to the medically needy, the State plan must:

(1) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:

(i) Such income levels must be comparable as among individuals and families of varying sizes;

(ii) Except as specified in paragraph (c)(1)(iii) of this section, the income levels for maintenance must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment programs, that is:

(A) In the case of families of three or more, at the level of the payment standard of the State plan approved under title IV-A generally applied;

(B) In the case of individuals, or families (including families with children) of two persons, at the higher of:

(1) The payment standard of the State plan approved under title IV-A generally applied, or

(2) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind and disabled) who are (or would be, except for income) eligible for benefits under title XIX;

except that this subparagraph (B) shall not be construed to require the provision of medical assistance

to any aged, blind or disabled individual who would not be eligible under the medical assistance standards in effect in such State for January, 1972.

Statement of the Case

A. The Respondents

Respondents, plaintiffs in the district court, are the wife and children of George Aitchison, a chronic care patient in a nursing home. Mr. Aitchison has received medical assistance since October 1974.*

The respondents live in Rockland County, New York. They are a family of two for the purpose of determining their medical assistance exempt income in this action.** The exempt income level for a family of two is $3800, or $317 monthly, under New York Social Services Law ("NYSSL") § 366(2)(a)(8). It is the highest Supplemental Security Income ("SSI") payment generally available for families of that size in New York.

George Aitchison's monthly income is $611.11, largely from a pension program and social security disability benefits. Respondent Marion Aitchison's monthly income is $250.39, and respondent Janice Aitchison's monthly income is $118, largely from social security disability benefits (A. 134). Marion Aitchison's monthly income (with Janice's payment toward her own support) exceeds the $317 level, and she is therefore required to pay the overage, $51.59, toward the cost of Mr. Aitchison's nursing home care.

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* The facts are established by Stipulations dated September 9, and September 24, 1975.

** George Aitchison is not included in computing the family's medical assistance exempt income because he is in chronic care. 18 NYCRR § 360.5(e). Respondent Michael Aitchison was excluded from the family budget by Stipulation dated September 9, 1975.

NYSSL § 366(2)(b); 18 NYCRR § 360.7(a). Since Marion Aitchison does not require contribution from George Aitchison to meet the exempt income level, George Aitchison's income (less an allowance of $28.50 for personal needs) is paid toward the cost of his nursing home care. 18 NYCRR § 360.5(e).

Had Marion Aitchison qualified of AFDC in Rockland County for herself and Janice, she would have received a "two person" "flat grant" for basic needs of $150 monthly [NYSSL § 131-a(3)] plus a shelter allowance at actual cost up the Rockland County maximum of $220 monthly. NYSSL § 131-a(2); 18 NYCRR § 352.3(a). Since the rent for the respondents' apartment is $250 per month, they would have received the $220 maximum. Thus, the difference between what Marion Aitchison and Janice would be paid if they were AFDC recipients ($150 + 220 = $370) and what they may retain as dependents of a medical assistance recipient ($317) is approximately $53 a month. Of course, respondents cannot in fact qualify for AFDC because their income exceeds the New York public assistance 'standard of need.' NYSSL § 131-a(3). In addition, had they sought to qualify for AFDC they could not retain other exempt property which New York allows to medical assistance recipients but not to public assistance recipients. E.g. NYSSL § 366(2)(a)(1) homestead exemption; NYSSL § 366(2)(a)(3) life insurance and burial reserves in excess of that allowed to public assistance recipients under 18 NYCRR §§ 352.24, 352.26; NYSSL § 366(2)(a)(4) savings equal to one-half income exemptions allowed. See 18 NYCRR § 360.7(a).

On the basis of the facts in the record, the respondents cannot afford to maintain their current standard of living regardless of whether they are medical assistance recipients or AFDC recipients because their rent is too high to be fully credited under either program.

B. Prior Proceedings

The Amended Complaint challenges the exempt income levels for medical assistance recipients established by NYSSL § 366(2)(a)(8) and related state regulations as applied to recipients whose shelter cost exceeds the averaged shelter component used to compute the levels and who therefore retain less exempt income under the medical assistance program than they would be paid if they qualified for AFDC where variable shelter allowances are available.* Amended Compl't ¶¶ 12-25. Respondents contend that this alleged difference in results between the AFDC 'standard of need' and the medical assistance income levels denies them the equal protection of the laws and privileges and immunities of citizens of the United States. Amended Compl't ¶¶ 26-27, 34-35. They contend further that this difference in results violates the "payments standards" provisions of 45 C.F.R. § 248.3(c)(1) and the "comparable standards" provision of 42 U.S.C. § 1396a(a)(17). Amended Compl't ¶¶ 28-29, 30-33.

The jurisdiction of the district court was alleged under 28 U.S.C. §§ 1331 and 1343(3) and (4). Amended Compl't ¶¶ 2-3. Declaratory and injunctive relief was sought against NYSSL § 366(2)(a)(8) as applied. Amended Compl't, Prayer for Relief. A class action order was sought (Amended Compl't ¶¶ 7-10), and a three-judge court was

* State and locally funded Home Relief incorporates the same variable shelter allowances. However, the medical assistance program here in issue is limited to "federally-related" recipients, i.e. those individuals who, but for their income and resources, would qualify for AFDC or SSI. 42 U.S.C. §§ 1396a(a)(10)(C), 1396d(a); 45 C.F.R. § 248.1(a). Of these two programs, only AFDC incorporates variable shelter allowances. Respondents have selected the AFDC 'standard of need' for purposes of comparison in this action and claim it to be the "higher payment standard" required by 45 C.F.R. § 248.3(c)(1)(ii). New York provides medical assistance to "Home Relief-related" individuals. The income eligibility levels for such recipients are set forth in 18 NYCRR § 360.3, not NYSSL § 366(2)(a)(8), and are not involved in this action.

requested on the constitutional issues. Amended Compl't, Prayer for Relief.

The claim of inconsistency between NYSSL § 366(2)(a)(8) as applied and 45 C.F.R. § 248.3(c)(1) was determined first by the single district judge [*Hagans* v. *Lavine*, 415 U. S. 528, 543-545 (1974)] on respondents' motion for summary judgment and on petitioner's motion for summary judgment dismissing the Amended Complaint for want of a substantial federal question and, in the alternative, for judgment in his favor on the statutory claim.

The district judge found respondents' equal protection claim sufficiently substantial to vest the court with subject matter jurisdiction under 28 U.S.C. § 1343(3). App. B, p. 7a. He granted the class action motion (App. B, pp. 7a-8a) and defined the class as "all applicants for and recipients of medical assistance only who[,] by reason of the application of New York Social Services Law § 366(2)(a)(8) and 18 NYCRR §§ 360.5(e) and 360.7(a), retain less monthly exempt income than the standard of need for families of the same size, paying the same shelter cost (plus cost of fuel where applicable) and living in the same social services district who have qualified for categorical public assistance under the Aid to Families with Dependent Children program." App. C, p. 24a. With respect to respondents' claim of inconsistency between the state statute and regulations and the federal regulation, the district judge first observed that "New York law complies with the introductory sentence of 45 C.F.R. § 248.3(c)(1) by specifying 'levels of income * * * for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance.'" App. B, p. 9a. He then held that New York was out of compliance under certain subdivisions of the regulation because, in his view, the use of averaged shelter cost to obtain the "levels of income" established a 'synthetic' AFDC standard rather than "the level of the [AFDC] payment standard . . .

generally applied" or "generally used" as required by the terms of the regulation. 45 C.F.R. § 248.3(c)(1)(ii). App. B, pp. 9a-13a. The allegedly synthetic standard was found to materially disadvantage the class (App. B, pp. 9a-12a) and the goal of regulatory simplicity as readily achieved with individualized determinations for class members. App. B, pp. 10a-11a, 15a. The Order and Judgment (App. C) as modified (App. D) allowed petitioner and the local social services seventy-five days in which to recompute the exempt income levels of class members.

The Court of Appeals affirmed on the district court opinion. App. A, p. 2a. The Court of Appeals granted petitioner's requests for a stay of the Order and Judgment of the District Court pending disposition of an expedited appeal and for a stay of its mandate pending filing of this Petition for Certiorari. As noted (footnote, p. 2, *ante*), petitioner undertook to file his Petition on an expedited basis on or before March 31, 1976. In view of the delay of several days, petitioner's and respondents' attorneys have agreed to treat the Court of Appeals stay as expired on March 31 and to deduct the business days between that date and the filing hereof from the seventy-five day compliance period allowed under the Order and Judgment of the District Court as modified. App. D.

C. Exempt Income Levels Under the Medical Assistance Program and the AFDC 'Standard of Need.'

Medical assistance (42 U.S.C. § 1396 *et seq.*, added July 30, 1965) is another example of "co-operative federalism. *King* v. *Smith*, 392 U.S. 309, 316 (1968). As in categorical public assistance programs,* a state may elect to participate in the medical assistance program under an ap-

* There are two remaining categorical assistance programs: Aid to Families with Dependent Children (AFDC), 42 U.S.C. § 601 *et seq.*, and Supplemental Security Income (SSI), 42 U.S.C. § 1381 *et seq.*

proved state plan (42 U.S.C. § 1396a) and obtain a federal grant, or share, in varying percentages, of the total cost of allowed items and services. 42 U.S.C. §§ 1396, 1396b. The state plan must include the categorically needy (AFDC and SSI recipients) and at the option of the state, may also include the "medically needy." 42 U.S.C. §§ 1396a(a)(10)(A)(B)(C), 1396d(a). "Medically needy" individuals are those whose income and resources exceed the eligibility requirements for categorical assistance but are inadequate to meet the cost of necessary medical and remedial care. *Id.;* 45 C.F.R. § 248.1(a). Such individuals must meet all other requirements of categorical assistance, i.e. they must be 'federally-related.'

Insofar as pertinent, federal statutes require that the medical assistance available to any categorically eligible individual be "no less in amount, duration or scope" than that available to any other such individual and no "less, etc." than that available to the medically needy. 42 U.S.C. § 1396a (a) (10) (A) (B) (i) (ii). Medically needy individuals are entitlted to have their eligibility determined in accordance with standards "comparable" to those employed in determining eligibilty for categorical public assistance. 42 U.S.C. § 1396(a) (10) (C) (i). Such assistance must be "equal in amount, duration and scope" with the medically needy group. 42 U.S.C. § 1396(a) (10) (C) (ii). There is no requirement that the medical assistance available to the medically needy be identical with or equal to that available to the categorically eligible.* The states must establish "reasonable standards" "comparable for all groups" for determining eligibility and the amount of aid. 42 U.S.C. § 1396a(a)(17).

* Categorical eligibility for medical assistance and the individuals included in that class are sometimes referred to in the text as "public assistance-medical assistance," or "PA-MA." Eligibility based on medical need and the individuals included in that class are sometimes referred to in the text as "medical assistance only" or "MA-only."

With respect to the medically needy (MA-only), the federal implementing regulation, 45 C.F.R. 248.3(c), requires that in determining eligibility, the state plan "[p]rovide levels of income . . . in total dollar amounts" [subd. (c)(1)]. The "income levels must be at the higher of the payments standards generally used as a measure of financial eligibility" in categorical assistance programs [subd. (c)(1)(i)]. "Higher . . . payments standards" is further defined as "the level" of the AFDC "payment standard for families of three or more [subd. (c)(1)(ii)(A)] and the higher of the AFDC "payment standard" or the "highest [SSI] level of payment . . . generally available" for individuals and families of two [subd. (c)(1)(ii)(B)]. The relevant regulatory history of § 248.3(c)(1) states that "medically needy levels must be uniform among individuals and families of similar size" and that the levels are to be tied to the "higher payment standard generally available" in categorical assistance programs. 39 Fed. Reg. 9513 (March 11, 1974.)*

Effective April 30, 1966, New York State elected to participate in the medical assistance program. NYSSL § 363 *et seq.*, added by C. 256 § 3 of the Laws of 1966. From the outset, the New York plan has included both the categorically eligible (PA-MA) and the medically needy (MA-only). NYSSL § 366(1).** Categorically eligible individuals receive public assistance benefits computed under

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* The regulation was formerly numbered 248.21(3) and provided, insofar as pertinent, that "income levels for maintenance" be "at the levels of the most liberal [rather than higher]" categorical assistance program [former subd. (3)(i)(b), 1973 ed.]. Section 248.21 was adopted effective January 28, 1969, 34 Fed. Reg. 1320. The present form of the regulation, § 248.3(c), was adopted effective March 11, 1974. 39 Fed. Reg. 9512.

** NYSSL § 366(1)(a) also provides medical assistance for state and locally funded Home Relief eligibles. As noted, footnote p. 10, *ante*, the medical assistance provided such individuals is not involved in this action because they are not "federally related."

applicable program requirements plus allowed medical and remedial items and services. AFDC eligibility and benefits paid for non-medical needs are measured under the New York 'standard of need' which, insofar as pertinent, consists of a "flat grant" for food, clothing and incidentals which varies according to assistance group size plus a shelter allowance equal to the actual cost of rent up to a maximum which varies according to assistance group size and social services district. NYSSL § 131-a(2), (3); 18 NYCRR § 352.3(a). SSI consists of a flat grant for all non-medical needs. Amounts vary according to living arrangements and assistance group size. 42 U.S.C. § 1381 *et seq.*; NYSSL § 207 *et seq.*

For the medically needy (MA-only), NYSSL § 366(2)(a) and related regulations, 18 NYCRR §§ 360.5(e) and 360.7(a),* provide for the exemption of certain resources, allowances and income, including annual (net) exempt income in accordance with scheduled amounts varied by family size. The net income schedule, as updated from time to time, is set forth in NYSSL § 366(2)(a)(8) and was established, *inter alia*, to implement 42 U.S.C. §§ 1396a(a)(10)(C), 1396a(a)(17) and 45 C.F.R. § 248.3(c)(1). It sets forth uniform exempt income levels expressed in "total dollar amounts" at "the level" of the AFDC "payment standard" for families of three or more and at the "highest [SSI] level of payment . . . generally available" for individuals and families of two since that level is higher than the AFDC payment standard for those categories. See 45 C.F.R. § 248.3(c). The "level" of the AFDC "payment standard" is the NYSSL § 131-a(3) AFDC "flat grant" for basic needs for the appropriate family size and the average,

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* The state regulations generally track NYSSL § 366(2)(a) and do not present any separate issue on this Petition for Certiorari. They are not considered further herein unless expressly referred to in the text.

or "mean," shelter cost paid by AFDC families of the same size rounded up to the nearest hundred.*

Two results follow from using the mean shelter cost paid by AFDC families (rather than variable shelter allowances permitted such families under the AFDC 'standard of need') to compute the MA-only exempt income levels: medical assistance recipients whose shelter costs exceed the mean retain less exempt income than they would be paid if their shelter costs were reimbursed by AFDC since, under that program, they would receive the difference between the mean and the local maximum; and medical assistance recipients whose shelter costs are less than the mean retain more than they would be paid as AFDC recipients since they retain more than their actual costs.**

In petitioner's view, the use of mean shelter cost to establish medical assistance exempt income levels conforms with 45 C.F.R. § 248.3(c)(1) since it enables the statement of *"the level* of the payment standard" [subd. (c)(1)(ii)(A)] "in *total dollar amounts*" [subd. (c)(1)] which are *"uniform"* within family sizes. 39 Fed. Reg. 9513 (March 11, 1974) (Emphasis added). Moreover, the use of mean shelter cost does not materially alter the AFDC 'standard of need' since it merely represents the "flat granting" or "consolidation" of a formerly variable cost item into a uniform cost item. Assuming that the averaging procedure is properly executed, conversions from variable to consolidated or "flat" grants do not affect a change in the content of the "standard" being converted. Program Instruction APA-PI-74-17, HEW 1974, App. E; Guidelines

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* In the event petitioner prevails on this appeal, respondents intend to challenge the accuracy of the AFDC shelter cost averaging on the remand of the case to the district court. App. B, pp. 11a, n. 32, 20a.

** Of course a third result is possible: medical assistance recipients whose shelter costs are equal to the mean retain the same amount they would be paid as AFDC recipients.

for the Development of Consolidated AFDC Assistance Standards (Excerpts), HEW 1974 (hereinafter "HEW Guidelines"), App. F.

In respondents' view and that of the district court, the use of mean shelter cost does not conform with 45 C.F.R. § 248.3(c)(1) because it allegedly does not result in a "generally used" [subd. (c)(1)(ii)] or "generally applied" [subd. (c)(1)(ii)(A) and (B)(1)] "payment standard" and because it materially alters the AFDC 'standard of need' which the regulation is alleged to mandate as to those medical assistance recipients who retain less than they would be paid as AFDC recipients. App. B., pp. 8a-15a.

New York has averaged the shelter cost of AFDC recipients to obtain "the level of the [AFDC] payment standard" under 45 C.F.R. § 248.3(c)(1) and exempt income levels under NYSSL § 366(2)(a)(8) from the outset of its participation in the medical assistance program. The New York State Medical Assistance Plan, incorporating NYSSL § 366(2)(a)(8), was initially approved by the HEW Region II Commissioner on April 1, 1970. Letter of April 1, 1970 from James C. Callison to George K. Wyman. On December 31, 1974, following the adoption of 45 C.F.R. § 248.3(c) (to replace § 248.21), the HEW Region II Commissioner again approved the New York Plan as complying, *inter alia,* with the regulation. Notice of Approval, dated December 31, 1974, signed by Elmer Smith. The district court's characterization of these HEW approvals as possibly inadvertent because the use of mean shelter cost does not show on the face of the statute is frivolous. App. B, pp. 12a-13a. Only the use of averaged costs could result in uniform income levels such as appear on NYSSL § 366(2)(a)(8). The use of variable costs would have resulted variable levels or possibly maximums. The NYSSL § 366(2)(a)(8) levels show on their face that they are neither variable and nor maximums.*

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* HEW must also have known that the statement of a single income level for each family size under NYSSL § 366(2)(a)(8) was not identical with the AFDC 'standard of need' consisting, *inter alia,* of "flat" grants and variable shelter allowances. NYSSL § 131-a (2), (3); 18 NYCRR § 352.3(a).

The only adverse comment which the New York State Department of Social Services ("NYSDSS") received from HEW concerning compliance of NYSSL § 366(2)(a)(8) with 45 C.F.R. § 248.3(c)(1) was directed to subdivision (c)(1)(ii)(B)(2) of the regulation and stated: "Due to a series of factors, the cash assistance standards have become more liberal than the MA standards for most family sizes." HEW Compliance Questions, dated May 7, 1975, for Quarter Ending March 31, 1975. NYSDSS understood the comment to refer to an updating of the NYSSL § 366 (2)(a)(8) levels, particularly those for individuals and two person families since the reference was to subdivision (B)(2). The levels for one and two person households (and for other family sizes) were in fact updated after the HEW comment by chapters 480, § 1 and 481, § 3 of the Laws of 1975 to produce the schedule currently in force. See p. 4 *ante*.* NYSDSS has not received further comment from HEW. In no event can HEW's general comment referable to March 1975 provide the basis for a challenge to the choice of averaged rather than variable shelter cost in establishing the NYSSL § 366(2)(a)(8) levels.**

There are approximately 188,233 recurring medical assistance cases in New York. Approximately 67,000 of these cases are in New York City. Five thousand new applications a week are filed in New York City, and 250,000 federally-related medical assistance applications for hospital coverage are filed on an annual basis. Compliance with the Judgment and Order of the District Court, as affirmed by the Court of Appeals, requires as a minimum that all current cases (those receiving aid as of December 3, 1975 and those filed after that date) be reviewed by the local social services districts to determine which recipients are class members and with respect to them, additional information on shelter costs obtained and continuously updated so as to provide individualized shelter credits.

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* Upward adjustments for one and two person households were effective July 1, 1975. Upward adjustments for other family sizes were effective October 1, 1975.

** The district court refers to the HEW comment but does not rely on it in support of its view that the "averaging methodology" is non-conforming. App. B., pp. 13a, 21a, n. 38. However, the district court fails to note that the NYSSL § 366(2)(a)(8) levels were in fact updated following the comment. *Id.*

Reasons for Granting the Writ

The petitioner's interpretation of the federal regulation should have been accepted as controlling given its consistency with the regulatory terms, history, federal statutory predicates, and HEW's approval of state practice. No more persuasive or even consistent opposing interpretation was offered. Moreover, to the extent that the decisions below hold that New York cannot average shelter cost to determine exempt income levels for the medically needy because its AFDC 'standard of need' allows variable shelter cost, they oppose principles established by this Court in *Rosado* v. *Wyman*, 397 U.S. 397 (1970), and HEW Guidelines. If not reversed, the decisions have far-reaching consequences for New York and other states which must rely on the ready convertibility between "averaged" or "flat" grants and "variable" or "individualized" allowances in the administration of their social welfare programs.

1. *The use of averaged rather than variable shelter cost in computing exempt income levels for the medically needy conforms with the express terms of 45 C.F.R. § 248.3(c)(1), its regulatory history and its federal statutory predicates. It is an HEW approved state practice. Respondents' interpretation of 45 C.F.R. § 248.3(c)(1) requires non-conforming practice.*

45 C.F.R. § 248.3(c)(1) establishes certain limitations on the determination of exempt income levels for medi-

cally needy individuals. The regulation provides in terms that the "*levels* of income" be expressed in "*total dollar amounts*" [subd. (c)(1)] at the "higher of the *levels of the payments standards* generally used as a measure of financial eligibility" on categorical assistance programs [subd. (c)(1)(ii)]. (Emphasis added).* "Higher . . . *levels of payments standards*" is further defined as "*the level* of the [AFDC] *payment standard*" for families of three or more [subd. (c)(1)(ii)(A)] and for individuals and families of two, as either the AFDC "*payment standard*" or "[t]he highest [SSI] level of payment . . . generally available," whichever is higher [subd. (c)(1)(ii)(B)(1)(2)]. (Emphasis added.) Upon the adoption of the regulation in its present form, HEW stated that the regulation required that "medically needy [income] levels must be uniform among individuals and families of similar size." 39 Fed. Reg. 9513 (March 11, 1974). See discussion p. 14, *ante*.

Both sides agree that the NYSSL § 366(2)(a)(8) exempt income levels obtained by combining the AFDC flat grant and average shelter cost for the appropriate family sizes** conform with 45 C.F.R. § 248.3(c)(1) in that they set forth "levels of income . . . in total dollar amounts." App. B, p. 9a. The dispute thus focuses on whether the terms "the level of the [AFDC] payment standard . . . generally applied" in subdivision (c)(1)(ii)(A) and "[t]he [AFDC] payment standard . . . generally applied"

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* The term "higher" in subdivision (c)(1)(ii) refers to the basis for choosing between the available "payments standards," either AFDC or SSI. It does not require that either the AFDC or SSI "payment standard" be maximized. See *Jefferson* v. *Hackney*, 406 U.S. 535, 539-545 (1972).

** The exempt income levels for individuals and families of two are the "highest [SSI] level of payment generally available" [45 C.F.R. § 248.3(c)(1)(ii)(B)(2)] since that level is higher than "the [AFDC] payment standard" so obtained [subd. (c)(1)(ii)(B)(1)].

in subdivision (c)(1)(ii)(B)(1) permit the use of mean AFDC shelter cost or whether they require the adoption of the state's AFDC 'standard of need,' incorporating variable shelter allowances, for the medically needy whose shelter costs exceed the AFDC mean.* See discussion pp. 11-12, *ante*.

Petitioner reads the quoted terms as obligating NYSDSS to establish a single level (i.e. "the level") for each family size under the AFDC "payment standard" "generally applied" or "generally used" [subd. (c)(1)(ii)]. As a result, NYSSL § 366(2)(a)(8) establishes one and only one income level for each family size and that level is pegged to the mean payment, the average of all payments made under the AFDC standard in common use.

To obtain the single "level of the [AFDC] payment standard," it is necessary to average the practically infinite variety of shelter cost payments (ranging from $0 to the maximums of the 58 local social services districts.) There is simply no other logical alternative: the incorporation of the variable shelter allowance permitted AFDC recipients must result in as many "levels" as there are allowances contrary to the terms of the regulation; the adoption of a maximum, while it will result in single "level," does not result in the level of a "payment standard" but rather in a "maximum" of a "payment standard," again contrary to the terms of the regulation and contrary to this Court's holding in *Jefferson* v. *Hackney, supra,* which rejected an alleged obligation on public welfare officials to adopt a computational method which would maximize benefits.

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* 45 C.F.R. § 248.3(c)(1)(ii) also uses the term "levels of payments standards generally used." Since the term is further defined in subdivision (c)(1)(ii)(A) and (B) as the choice between the higher of "the level of the [AFDC] payment standard" and the "highest [SSI] level of payment," it is not separately considered unless specifically referred to.

As noted, p. 20 *ante,* petitioner's reading the regulation as requiring the obtaining of a single exempt income level for each family size and the use of mean shelter cost to obtain such levels conforms with the relevant regulatory history requiring "uniform" levels within family sizes, 39 Fed. Reg. 9513 (March 11, 1974), as well as with the introductory sentence in subdivision (c)(i) requiring that "levels of [exempt] income be expressed in total dollar amounts." Absent the use of mean shelter cost (or the use of maximums for which there is no authority), there would be no uniformity within family sizes and no "levels" of exempt income expressed in "total dollar amounts."

HEW has twice approved NYSSL § 366(2)(a)(8) as conforming, first in April of 1970 and then in December of 1974 after 45 C.F.R. § 248.3(c)(1) had been promulgated in its present form. See discussion p. 17, *ante.* In petitioner's view, these approvals include the use of mean shelter cost to obtain the § 366(2)(a)(8) levels. As noted, variable shelter cost which HEW must have known was incorporated in the AFDC 'standard of need' under the New York AFDC plan it had approved could not produce the uniform levels that appear in § 366(2)(a)(8), and there has never been any suggestion from HEW that maximums were the appropriate means of obtaining the "level" of a payment standard. Indeed, HEW's view must accord with petitioner's since departmental Guidelines state that the "flat granting" of a variable cost item is proper if it is pegged to the "fair average" of the former cost, not to a maximum. See App. F, pp. 33a-43a and discussion, pp. *post.*

The federal statutory predicates of 45 C.F.R. § 248.3 (c)(1) are equally supportive of petitioner's reading of the regulation. Both sides agree that 42 U.S.C. §§ 1396a (a)(10)(C) and 1396a(a)(17) are the authorities of the regulation. Petitioner's Brief in the Court of Appeals, pp. 12-13; Respondents' Brief in the Court of Appeals,

p. 2. Section 1396a(a)(10)(C) states that if a state provides medical assistance to the medically needy (MA-only), that assistance must be "equal in amount, duration and scope" for all such (MA-only) individuals [subd. (C)(ii)].* Section 1396a(a)(17) states that a state plan must include "reasonable standards . . . for determining eligibility for and the extent of medical assistance" which "shall be comparable for all groups." As the plain meaning of the words of these statutes state, comparability, not identity or equality, is required across PA-MA and MA-only groups. The statutes do not require that medically needy individuals receive the same or no less credit than categorical recipients receive cash grants. Indeed, by requiring identity only within the PA-MA group and within the MA-only group, § 1396a(a)(10)(A)(B)(C) specifically admits of the results obtained under NYSSL § 366(2)(a)(8), i.e., that all medically needy individuals receive medical assistance equal in "amount, duration and scope" within the same family sizes albeit that assistance may not be "equal in amount, duration and scope" to that provided to PA-MA families. See discussion p. 13, *ante.*

Respondents' opposition to petitioner's interpretation of 45 C.F.R. § 248.3(c)(1), as expressed by the district court, requires that non-conforming practice be adopted and is surely no more persuasive than offered by petitioner. Under the district court's reasoning § 248.3(c)(1) requires the importation of the AFDC 'standard of need,' since any other basis for determining exempt income levels must be an *"ad hoc* 'ADC payment standard' " or a "synthetic ADC payment standard" in violation of the regulation.

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* Section 1396a(a)(10)(A)(B)(i)(ii) states that medical assistance provided for the PA-MA group shall be "equal in amount, duration and scope" within that group and no less than that provided to the MA-only group.

App. B, p. 11a.* Principal reliance is placed on the regulations terms "generally used" and "generally applied." App. B, p. 12a.

In opposition, petitioner notes that the regulation does not use the term AFDC 'standard of need' (or "actual ADC standard"), either of which could have been selected by HEW, and that the terms "generally used" and "generally applied" modify the term "payment standard" or "payment standards" not the term "the level". Thus the regulatory term, "the level of the [AFDC] payment standard . . . generally applied" [subd. (c)(1)(ii)(A)] means a single level drawn from monies paid under the AFDC program in ordinary course. It does not mean, as the district court's reasoning would require, levels of payment generally available under the AFDC 'standard of need.'

In addition, the incorporation of variable AFDC shelter allowances to determine all or part of the "payment standard" must result in different (as opposed to "uniform") exempt incomes (as opposed to "levels") in every case it is applied both within a given family size and across family sizes, results inconsistent with the relevant regulatory history. It must also result in exempt incomes expressed in varying (as opposed to "total") "dollar amounts" in violation of the first sentence of the regulation [subd. (c)(1)].**

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* This is so if, as the district court appears to hold, the term AFDC "payment standard" is read as synonymous with "actual ADC standard." App. B, p. 11a. Thus, any departure from the "actual ADC standard" (currently 100% of the AFDC 'standard of need'), whether by a single uniform level for each family size or by a combination of such levels and maximums, as respondents suggested below, creates a "synthetic," and illegal standard because it is perforce not the "actual ADC standard." *Id.*

** Although the district court attempted at some length (App. B, pp. 10a-11a) to accommodate the varying dollar amounts which resulted from its interpretation with the requirement of "total

(footnote continued on following page)

Moreover, the incorporation of the variable AFDC shelter allowances in the "payment standard" opposes the federal statutory predicates of § 248.3(c)(1) by requiring identity between PA-MA and MA-only groups when the statutes themselves require only comparability and admit of differences in medical assistance credits. See discussion, pp. 22-23 *ante*.*

2. *The use of averaged rather than variable shelter cost in computing exempt income levels does not diminish the AFDC 'standard of need.' It is simply a change in computational method, sanctioned both by this Court in* Rosado v. Wyman, 397 U.S. 397 (1970), *and by HEW which enables the conversion of variable cost items to uniform cost items. The continuing ability of the states to make these conversions bears directly on their capacity to administer social welfare programs.*

The district court's finding of inconsistency between NYSSL § 366(2)(a)(8) and 45 C.F.R. § 248.3(c)(1) rests

(footnote continued from preceding page)

dollar amounts," one cannot fairly read the requirement as "merely calling for an objective, efficient standard for determining eligibility" or as allowing any computational method which will reduce itself to "flat dollar amounts". App. B, p. 11a. "[T]otal dollar amounts" are also not the same as "money amounts" [45 C.F.R. § 233.20(a), App. B, pp. 11a, n. 31, 20a] which accommodate any computational method which can be expressed in dollars and thus allow for varying individual results. At a minimum, the court's interpretation of "total dollar amounts" is no better than that offered by the petitioner, and petitioner's should be accepted as controlling in light of HEW's approval.

* At footnote 41 of the opinion (App. B, p. 22a), the court excerpts a portion of Senate Report No. 404, 1 U.S. Code Cong. & Admin. News 1943, 2019 (1965) in support of the view that Congress did not intend MA-only credits to fall below cash grants in any given case. However, the references in the excerpt to "State plan" refer to the medical assistance state plan, not the AFDC state plan, and the "test of eligibility" cited likewise refers to the eligibility standards of the medical assistance plan.

in large measure on the erroneous view that the use of averaged shelter cost to obtain the exempt income levels diminishes the AFDC 'standard of need.' App. B, pp. 11a-15a.

It is unquestioned that the averaging or "flat granting" of an item of need which was formerly allowed under a variable "standard" results in a single cost for that item, or a uniform standard. Thus, the "flat granting" of AFDC shelter costs to obtain the § 366(2)(a)(8) levels necessarily results in the " 'averaging away' " of the practically infinite variety of shelter allowance payments. HEW Guidelines, App. F, p. 35a. However, it does not follow that this conversion from a variable to a uniform standard diminishes or materially alters the variable standard. Contrary to the district court's view, the resulting uniform standard is neither "ad hoc" nor "synthetic;" it is not "sometimes adequate" and "sometimes not." App. B, p. 11a. The uniform standard is the "fair average" of the variable "standard" and is therefore simply another, equally "real," way of describing the same thing. Assuming that the fair averaging procedure has been properly executed, the uniform standard is always an "adequate" statement of the variable standard.

The principles supporting petitioner's view of the ready convertibility between variable and uniform standards are well-established. In *Rosado* v. *Wyman,* 397 U.S. 397 (1970), this Court expressly recognized the convertibility of a variable to a "flat" or uniform standard within the AFDC program, stating 397 U.S. at 419:

> We do not of course, hold that New York may not, consistently with the federal statutes, consolidate items on the basis of statistical averages. Obviously such averaging may affect some families adversely and benefit others. Moreover, it is conceivable that the net payout, assuming no change in level of benefits, may

> be somewhat less under a streamlined program. Providing all factors in the old equation are accounted for and fairly priced and providing the consolidation on a statistical basis reflects a fair averaging, a State may, of course . . . redefine its method for determining need.

HEW materials are to the same effect. A properly developed "consolidated ['flat grant' or 'uniform'] standard does not result in overall reduction in the content of the existing [variable] standard" (HEW guidelines, App. F, p. 40a), and it may be applied specifically to shelter costs. If a uniform standard reduces an existing standard, the uniform standard is illegal not because uniformity has been obtained, as the district court held, but because the fact of a reduction constitutes a finnding that the items and amounts have not been "fairly averaged." *Id.,* pp. 37a-40a. See APA—PI—74-17. No such finding with respect to the averaging of shelter costs is contained in the record below.

If, as appears from the above discussion, a state may shift freely from variable to uniform costs within a given program, surely New York may shift freely from one to the other when it moves from public assistance to medical assistance. *Jefferson* v. *Hackney,* 486 U.S. 417, 549-551 (1972).

A uniform standard developed through fair averaging "assure[s] recipients an equitable distribution of funds." HEW Guidelines, App. F, p. 35a. It avoids "complicated standards which . . . attempt[ ] to explicitly relate . . . amounts of . . . payments to individual circumstances" and the "greater chance of error" incident to such "complicated standards" both as to interpretation of policy and technical detail. HEW Guidelines, App. F, p. 36a. The uniform standard also has a potential cost advantage to the administering agencies which can accrue to the re-

cipient, to the taxpayer, or both. See *Rosado* v. *Wyman, supra;* HEW Guidelines, App. F, p. 40a. The advantages of uniform standards accord fully with the goal of regulatory simplicity 45 C.F.R. § 248.3(c)(1) was intended to serve. 42 U.S.C. § 1396a(a)(17); App. B, pp. 14a, n. 40 p. 21a.

In the context of this case, the use of a uniform standard obtained by averaging shelter costs permitted the local social services agencies to determine eligibility solely upon an investigation of an applicant's income and resources. Under the district court opinion, as affirmed by the Court of Appeals, the local social services districts must, in addition, establish every applicant's shelter cost, to determine if he comes within the class. If he does, the information must be used to compute his individualized exempt income level. The information must then be continuously checked and updated by the local caseworker to insure that the determination remains correct. As is plain, this procedure does not merely involve filing an additional form, but is a lengthy and continuing investigation, applicable in New York to at least 200,000 cases annually, with all the disadvantages HEW has described. See discussion pp. 18-19, *ante*.

The choice between variable and uniform standards rests firmly in the discretion of the state legislatures and related administering agencies. They may select either the variable or uniform standard depending on their view of the relevant circumstances. Their choice in this regard has no legally cognizable effect on the recipients' standard of living. No federal law or regulation limits this choice regardless of the relationship or lack of relationship among the social welfare programs involved.

CONCLUSION

For the foregoing reasons, the instant Petition for a Writ of Certiorari should be granted.

Dated: New York, New York, April 8, 1976.

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Judgment of the United States Court of Appeals for the Second Circuit, Appendix A.

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

At a Stated Term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Courthouse in the City of New York, on the 13th day of February, one thousand nine hundred and seventy-six.

Present: HON. WILLIAM H. TIMBERS, Circuit Judge.
HON. FREDERICK vP. BRYAN,
HON. JAMES S. HOLDEN,
District Judges Sitting by Designation.

75-7673

MARION AITCHISON, et al.,
Plaintiffs-Appellees

v.

STEPHEN BERGER, et al.,
Defendant-Appellant.

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York, and was argued by counsel.

Judgment of the United States Court of Appeals for the Second Circuit, Appendix A.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged, and decreed that the judgment of said District Court be and it hereby is *affirmed* on the opinion of Judge Frankel dated November 12, 1975.

WILLIAM H. TIMBERS
United States District Judge

FREDERICK vP. BRYAN
United States District Judge
Sitting by Designation

JAMES S. HOLDEN
United States District Judge
Sitting by Designation

Opinion of the District Court for the Southern District of New York, Appendix B.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

75 Civ. 1224

MARION AITCHISON, et al.,

Plaintiffs,

against

STEPHEN BERGER, et al.,

Defendants.

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FRANKEL, D.J.

Ten years ago, Congress enacted Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396g, the so-called "Medicaid" legislation. Medicaid is a cooperative federal-state medical assistance program operated under state direction, subject to extensive federal statutory and regulatory guidelines. States are not required to participate in Medicaid, nor, if they do participate, to extend benefits to any persons other than those receiving federally-funded public assistance—sometimes referred to by responsible officials (and hereinafter) as "categorical assistance."[1] If, however, a State decides to participate in Medicaid, it must submit a plan that comports with federal law. If the plan includes aid for people not receiving categorical assistance but qualifying as "medically needy,"[2] the State must observe the additional federal requirements applicable to this group of recipients.[3]

New York has elected to participate in the Medicaid Program and to extend benefits to the medically needy.[4] The basic issues now before the court are whether New York's statutory and regulatory scheme setting income eligibility and retention levels for the medically needy[5] are compatible with applicable federal regulations,[6] and, if not, whether these federal regulations are themselves inconsistent with the Social Security Act.[7]

The plaintiffs are the wife and child of a disabled 54-year-old man who has been in a nursing home since 1972 and receiving medical assistance since October 17, 1974. As

a medically needy "family" of two,[8] plaintiffs, under New York's medical assistance law, are allowed to retain a total of $317 per month for their personal maintenance expenses. The monthly standard of need for a family of two receiving categorical assistance, living in the same county and paying the same rent as plaintiffs, is $370 per month. Thus, plaintiffs are allowed to retain $53 less a month for their maintenance than the comparable public assistance standard of need for a family of two.

The discrepancy results from a difference in computing shelter allowances. For ADC recipients, these allowances are based upon actual rents paid. For the medically needy family, the allowance has nothing to do with the family's actual rent. It is instead based on a figure computed from statewide averages, which may be above or below actual rent. For the class of plaintiffs before us it is, of course, below.

To spell out these arrangements, which are not evident from the face of the State's Medicaid statute and regulations:

> No ¶———Under the ADC provisions, each family of the same size receives a basic allowance of the same amount, plus an allowance for shelter based upon actual rent paid up to the maximum set for shelter in a given family's social service district (county). For example, a family of two eligible for ADC receives a basic monthly allowance of $150; if the family lives in Rockland County and pays $250 a month rent, as plaintiffs do, it is entitled to a monthly shelter allowance of $220, the maximum allowed in Rockland County. Thus, the total monthly public assistance standard of need for a family comparable to plaintiffs' in size, county of residence, and shelter costs, is $370.[9]

To arrive at the medical assistance income levels, defendants average the shelter allowances paid to all ADC

families of a given size and divide by the number of those families. The resulting "mean shelter allowance" is then added to the basic allowance to determine the income allowance for a family of that size.[10] Thus, some medically needy families are entitled to retain more, others less maintenance income than they would be paid if they were without any income and paid cash benefits under ADC. The crucial variable is shelter cost, more specifically, whether a given family's shelter costs exceed the shelter average.

Plaintiffs contend that this differential violates federal regulations. They seek to represent a class consisting of all persons in New York receiving medical assistance who are allowed to retain income for maintenance in an amount less than the applicable standard of need under New York's public assistance programs.[11]

Seeking declaratory and injunctive relief, plaintiffs assert rights under 42 U.S.C. § 1983, the Social Security Act, regulations promulgated thereunder, and the supremacy and equal protection clauses of the Constitution. They invoke the court's jurisdiction under 28 U.S.C. §§ 1331(a), and 1343(3) and (4). They seek to maintain the suit as a class action under Fed. R. Civ. P. 23(b) (2). Plaintiffs have moved upon affidavits and a series of stipulations subsequently submitted for (1) a declaration that this is a proper class action and (2) summary judgment on their claim that the maintenance income levels of section 366(2)(a)(8) of the New York Social Services Law and accompanying regulations,[12] as applied to the plaintiff class, violate 45 C.F.R. § 248.3(c). Defendants cross-move to dismiss the complaint for lack of jurisdiction. There do not appear to be any material issues of fact. For the reasons stated below, both of plaintiffs' motions are granted.

Jurisdiction

Jurisdiction in welfare cases is a recurrent issue, regularly resolved for plaintiffs.[13] Since the court concludes that plaintiffs' equal protection claim is not "wholly insubstantial" or "obviously frivolous," as those phrases have been construed by the Supreme Court,[14] jurisdiction exists under 28 U.S.C. § 1343(3) and there is no need to explore in detail the alternative jurisdictional bases asserted by plaintiffs. See *Schaak* v. *Schmidt*, 344 F. Supp. 99, 102-03 (E.D. Wisc. 1971). Suffice it to say that jurisdiction may also exist under 28 U.S.C. § 1331(a),[15] but apparently not under the other asserted provisions.[16] This court can pass upon plaintiffs' "statutory" claims without deciding whether a three-judge court should be convened to decide the merits of plaintiffs' equal protection claim.[17]

Class Action Motion

The question of class action treatment can also be dealt with summarily. Plaintiffs seek to represent all medically needy persons in New York who are required by defendants, pursuant to state statute and regulations, to live on a monthly income allowance which is below the level of need for categorical assistance families of the same size, living in the same county, and paying the same rent. This is a classic case for treatment as a class action under Fed.R.Civ. P. 23(b)(2). See, e.g., *Almenares* v. *Wyman*, 334 F. Supp. 512, 518-19 (S.D.N.Y. 1971), *modified* 453 F. 2d 1075 (2d Cir. 1972); *Wilczynski* v. *Harder*, 323 F. Supp. 509, 512 n. 3 (D. Conn. 1971); *Schaak* v. *Schmidt*, *supra* at 104. Defendants' argument that plaintiffs have failed to identify sufficiently the members of the class might carry some weight if this were a (b)(3) class ac-

tion where notice had to be given to class members. But it seems clear that there is no such requirement here. See *Frost* v. *Weinberger*, 515 F.2d 57, 65 (2d Cir. 1975).

INCONSISTENCY BETWEEN STATE AND FEDERAL LAW

While the issue is a difficult one, the court has concluded that the income levels in New York's medical assistance statute and regulations do not conform with the requirements of 45 C.F.R. § 248.3(c).

45 C.F.R. § 248.3(c)(1) requires that a state plan covering the medically needy "[p]rovide levels of income * * * for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance." The income levels referred to "must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment [categorical assistance] programs * * *." 45 C. F. R. § 248.3(c)(1)(ii). For families of three or more, the income level is to be at the level of the payment standard under a State's ADC program "generally applied." For individuals and families of two, the income level is to be at the ADC payment standard "generally applied" or at the level of payments "generally available" under the SSI program, whichever is higher. Finally, the income of the medically needy must be applied "[f]irst, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance" before any income may be applied to defray the costs of medical assistance. 45 C.F.R. § 248.3(c)(2).[18]

The corresponding state law is found in NYSSL § 366(2)(a)(8)[19] and N.Y.C.R.R. §§ 360.5(e)[20] and 360.7 (a)(5).[21] These provisions set forth levels of income, in total dollar amounts, which serve both as a basis for establishing eligibility for medical assistance and as the

level of income that may be retained for personal maintenance expenses by eligible medical assistance recipients.[22] Thus, New York law complies with the introductory sentence of 45 C.F.R. § 248.3(c)(1) by specifying "levels of income * * * for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance." The problems begin in subsequent subdivisions of the federal rule.

Subdivision (ii) of 45 C.F.R. § 248.3(c)(1) requires that the levels of income set be, "as a minimum, at the higher levels of the payment standards generally used as a measure of financial eligibility in the money payment programs [i.e., the ADC standard generally applied]."[23] It is undisputed, or in any event obvious, that plaintiffs and an undetermined number of other medical assistance recipients are allowed to retain less income for maintenance than they would receive for maintenance if they were categorically needy (i.e., eligibile for ADC assistance). Plaintiffs contend that this difference in level of maintenance income violates the requirement of § 248.3(c)(1)(ii) that maintenance income be set, as a minimum, at the level of the applicable ADC payment standard. Defendants counter that § 248.3(c)(1)(ii) requires that the income levels be set at or above the ADC "payment standard generally applied" and that there is no such standard in New York's ADC assistance scheme other than that found in NYSSL. § 366(2)(a)(8) and its accompanying regulations.

Under New York's ADC program, need is determined and benefits paid on a partially variable rather than totally flat grant basis. That is, for each family size, the standard of need, and identical payment standard,[24] consists of (1) a basic allowance in an amount equal for all families of a given size and (2) an allowance for shelter that varies from county to county and from family to family depend-

ing on the actual shelter costs incurred and the established county maximum.[25] Hence, defendants argue that there is no ADC payment standard "generally applied" and that the actual ADC payment "standard" could not possibly be used as the medical assistance eligibility standard because it is not expressed in "total or flat dollar amounts."

The argument is thin as semantics and no more robust as a matter of legal reasoning. It is not correct in any relevant sense to say that New York lacks any ADC payment standard "generally applied" and that the "total dollar amounts" language of 45 C.F.R. § 248.3(c)(1) necessarily requires that the medical assistance standard be expressed in flat dollar amounts.

The composite need formula of NYSSL § 131-a is New York's ADC payment standard.[26] That the application of this standard to families of the same size results in different amounts of need and corresponding grants does not vitiate it as a standard "generally applied." The legal world is filled with generally applicable standards that produce varying individual results because of varying individual circumstances responding to the material (and general) criteria.

Defendants' reading of "total dollar amounts" to preclude the use of the ADC methodology as the medical assistance standard is, similarly, a dry, scarcely inevitable, unpersuasive construction. It is true, as defendants say, that the "total dollar amounts" language of 45 C.F.R. § 248.3(c)(1) was adopted to implement the "reasonable standards" language of 42 U.S.C. § 1396a(a)(17)[27] and that this statutory provision was meant to ensure that the states adopted efficient methods of determining eligibility for medical assistance.[28] It is also true that NYSSL § 366(2)(a)(8), as would be true of any standard set in flat dollar amounts, is an efficient method of determining eligibility. But it does not follow at all from these two flawless premises that no variable standard can satisfy

the "total dollar amounts" requirement because such a standard is not expressed in flat dollar amounts.

The "total dollar amounts" language, fairly read in light of its purpose, merely calls for an objective, efficient standard for determining eligibility.[29] Such a standard could either be expressed in flat dollar amounts, as in NYSSL § 366(2)(a)(8), or be readily reducible to flat dollar amounts as is the actual ADC standard in NYSSL § 131-a.[30] Indeed, New York apparently agreed with this broader reading when it read very similar language in the ADC eligibility regulation[31] to allow it to adopt the variable standard now found in NYSSL § 131-a.

In spite of the existence of an actual ADC standard, defendants claim that NYSSL § 366(2)(a)(8) represents New York's only "ADC payment standard generally applied." This disputed provision was created for the purpose of setting income allowances for the medically needy. As described above, the figures in that provision were arrived at by (1) allegedly[32] averaging the shelter allowances paid to all families of a given size receiving categorical assistance and (2) adding that average to the appropriate basic allowance.

This ad hoc "ADC payment standard" does not mesh acceptably with 45 C.F.R. § 248.3(c)(1). To determine whether a State's medical assistance standard is high enough, the federal regulation requires that it be compared with the "generally used" public assistance eligibility standard. Defendants' synthetic ADC standard, used to determine eligibility for medical rather than categorical assistance, cannot be compared with itself to test its own adequacy. When matched with the proper (i.e., actual) ADC standard, the artificial ADC standard, as the embodiment of the medical assistance eligibility standard, is sometimes adequate, sometimes not, as in the case of the class members before us. Despite the obvious incompatibility of their artificial standard with the requirements of the fed-

eral regulation, defendants insist that the "generally used" language sanctions their averaging methodology.

There is no sound basis for defendants' textual argument that the "generally used" language of 45 C.F.R. § 248.3(c)(1)(ii) means or can mean a hypothetical "average" ADC payment standard.[33] As a matter of English, defendants' reading is hard to accept. New York's "average ADC standard" is never used, let alone generally used, as the ADC payment standard. That standard is found in NYSSL § 131-a. The fairer use of the federal phrase would seem to be, as plaintiffs suggest, to contrast the general ADC standard with occasional departures from that standard made to take care of special needs[34] and/or to take cognizance of the fact that some individuals were "grandfathered" into the SSI program even though they did not meet the generally used standard of SSI eligibility.[35]

In further support of their textual argument, defendants find significance in a change in the language from a predecessor regulation that required medical assistance eligibility standards to be set "at the levels of the most liberal money payment standards used by the State • • •." 45 C.F.R. § 248.21(a)(3)(i)(B). It seems plain, however, that the change in language was not intended to effect any substantive change, but was made merely to reflect the amalgamation of Titles I, X, XIV, and XVI of the Social Security Act into a new Title XVI (the SSI program). Thus, it no longer made sense to talk about the most liberal money payment standard when there were only two such standards remaining, ODC and SSI. Hence, the language was changed to "the higher of • • •." In Puerto Rico, Guam, and the Virgin Islands where SSI did not go into effect, the "most liberal" language was retained.[36]

Defendants' next argue that HEW's approval of New York's medical assistance plan demonstrates its validity. While HEW approval is some evidence of validity, it is

not controlling.[37] It is not more than slightly persuasive when, as here, the so-called approval does not appear to have followed explicit attention to the question now confronted. All that appears on the face of New York's medical assistance plan and NYSSL § 366(2)(a)(8) are income amounts with no indication of how these figures were arrived at or whether they are at, below, or above the ADC payment standard. The "averaging" technique is only discovered after specific exploration. Furthermore, HEW has recently notified New York, in a quarterly compliance report, that its cash assistance payment standards are impermissibly higher than its medical assistance standards. This casts doubt upon the latter standards, if not upon the underlying averaging methodology as such.[38]

This court concludes, as have other courts in closely analogous cases, that the State standard of care for its medically needy is in conflict with the governing federal regulations. See *Dominguez* v. *Milliken*, CCH Medicare and Medicaid Guide ¶ 26,633 (W.D. Mich. 1973); *Schaak* v. *Schmidt, supra; Schlemowitz* v. *Lavine*, 75 Misc.2d 529 (Sup. Ct. Nassau Co. 1973). Unless those regulations are themselves invalid, plaintiffs must prevail.

Validity of 45 C.F.R. § 248.3(c)

Defendants argue that if plaintiffs' interpretation of 45 C.F.R. § 248.3(c) is adopted, as it now has been, then the regulation is inconsistent with, and thus invalid under, 42 U.S.C. § 1396a(a)(17). For the reasons stated below, the court has concluded that the regulation is valid.

45 C.F.R. § 248.3(c) was apparently derived from 42 U.S.C. § 1396a(a)(17),[39] which requires state plans to "include reasonable standards • • • for determining eligibility for and the extent of medical assistance. • • •" Pertinent legislative history and administrative interpretation indi-

cate that the "reasonable standards" language encompasses at least two concepts: (1) regulatory simplicity[40] and (2) income levels set at or above the subsistence level under public assistance programs.[41] By requiring eligibility standards to be in "total dollar amounts" and at the level of the higher payment standard used in a State's money payment programs, 45 C.F.R. § 248.3(c) embodies both of these aims.

Defendants argue, that 42 U.S.C. § 1396a(a)(17) allows the states to formulate their own eligibility standards so long as they are "reasonable." Since New York's averaging methodology and resulting eligibility standards are said to constitute "reasonable standards," defendants urge the court to uphold the state statutory and regulatory scheme notwithstanding any contrary mandate in 45 C.F.R. § 248.3(c). Assuming *arguendo* that New York's eligibility standards are reasonable, that fact is irrelevant. The relevant inquiry is whether the federal regulation itself is a reasonable interpretation of 42 U.S.C. § 1396a(a)(17). See, e.g., *Edelman* v. *Jordan*, 415 U.S. 651, 660 n.8 (1974). This court, like others before it, concludes that it is. See *Dominguez* v. *Milliken, supra* at 9121 (upholding 45 C.F.R. § 248.21); *Schaak* v. *Schmidt, supra* at 103-04 (upholding 45 C.F.R. § 248-21).

Even if this were a contest as to which is more reasonable, the federal regulation would prevail. The programs in question are for real people with real needs, not statistical averages. Construing the legal documents liberally in favor of the needy,[42] it makes eminent sense to read the standards in terms of every individual or family, not to hold that it is sufficient if some average is accomplished.

To discriminate against the self-supporting by requiring them to live on income below the level declared by New York to be necessary for minimal maintenance would do violence to the aims of the Medicaid legislation and common sense. Our concern here is with people who have not

sought public assistance for routine support, but only to meet the catastrophe of serious illness. The court could not countenance for an instant the mean-spirited fiction that people driven to seek public assistance are somehow unworthy or undeserving. Nevertheless, it remains deep and familiar in our esteem for individual initiative that we would not deem it acceptable without some particular justification to treat those outside categorical assistance groups less generously than those within.[43] The unquestioned regulation, fairly read, reflects this philosophy. No good reason appears either for reading it differently or holding it invalid.

It may be noted, finally, that today's decision, on defendants' own analysis, does not entail any inevitable increase in the State's Medicaid outlays. Those who pay less than average shelter allowances for rent have in a sense been receiving windfalls. Nobody supposes these extra benefits are compelled as a matter of federal law or regulation. This court holds only that those disadvantaged by the Procrustean average are entitled individually to the concrete benefits of the federally mandated standards.

Having concluded that NYSSL § 366(2)(a)(8) and N.Y.C.R.R. §§ 360.5 and 360.7 are incompatible with 45 C.F.R. § 248.3(c) and that the federal regulation is valid, the court (1) declares the state statute and regulations invalid as applied to class members, (2) will enjoin defendants from enforcing these provisions against class members, and (3) will order defendants to compute the entitlements of class members on the basis hereinabove outlined, namely, to protect for maintenance amounts no less than those allowed to comparable ADC recipients.

Settie a final decree on notice.

Dated, New York, New York, November 12, 1975.

MARVIN E. FRANKEL
U.S.D.J.

FOOTNOTES:

1. 42 U.S.C. § 1396a(a)(10)(A)(1970). The federally-funded public assistance programs now in effect are the Aid to Families with Dependent Children Program ("ADC") and the Supplemental Security Income Program ("SSI") for the aged, blind, and disabled.

2. "An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care and services." 45 C.F.R. § 248.1(a)(2).

3. See 42 U.S.C. § 1396a(a)(10)(C).

4. New York Social Services Law ("NYSSL") §§ 363-a, 366 (McKinney Supp. 1974-75).

5. NYSSL § 366(2)(a)(8); New York Codes, Rules and Regulations ("NYCRR") §§ 360.5 and 360.7.

6. Primarily, 45 C.F.R. § 248.3(c)(1) and (2) (1974).

7. Primarily, 42 U.S.C. § 1396a(a)(17).

8. The parties have stipulated that when this action began, plaintiffs were a family of three, but are now a family of two. For purposes of determining family size for income maintenance and eligibility purposes, a family member in chronic care "shall not be deemed to be a member of any household." NYCRR § 360.5(e).

9. See NYSSL § 131-a(2) and (3); NYCRR § 352.2(e); 1975 Table of Local Agency Maximum Shelter Allowances with Heat, Exhibit A of Affidavit of Eleanor A. Sochocki, sworn to October 3, 1975.

10. Since the resulting figure for individuals and families of two is even lower than the SSI payment standard for individuals and two-person families, the SSI standard is used as the income retention level for these medically needy people. Federal law requires a State to set its income maintenance levels, for individuals and families of two, at the higher of the SSI and ADC payment standards. 45 C.F.R. § 248.3(c)(1)(ii)(B). See note 23 *infra*.

11. The two relevant state public assistance programs are contained in NYSSL §§ 345 through 358-e ("ADC") and §§ 207-212 ("SSI").

12. NYCRR §§ 360.5(e) and 360.7(a)(5).

13. But cf. *Andrews* v. *Maher*, Docket No. 75-7029 (2d Cir. October 24, 1975).

14. See, e.g., *Hagans* v. *Lavine*, 415 U.S. 528, 536-43 (1974); *Edelman* v. *Jordan*, 415 U.S. 651, 653 n. 1 (1974) (processing the claims of some applicants for welfare aid before those of similarly situated plaintiffs raises a not "wholly insubstantial" equal protection claim).

15. The parties have stipulated that defendants administer a medical assistance fund of some $3,000,000,000 and that if plaintiffs are successful in this action, the financial impact on the state medical assistance budget will be in excess of $10,000. Thus, plaintiffs' claims arguably satisfy the $10,000 jurisdictional amount requirement of 28 U.S.C. § 1331(a). See, e.g., *Bass* v. *Rockefeller*, 331 F. Supp. 945 (S.D.N.Y.), appeal dismissed as moot, 464 F.2d 1300 (2d Cir. 1971); *Yanez* v. *Jones*, 361 F. Supp. 701, 706 (D. Utah 1973); *Moore* v. *Betit*, 511 F.2d 1004, 1007 n. 12 (2d Cir. 1975). See also *Committee for GI Rights* v. *Callaway*, 518 F.2d 466, 472-73 (D.C. Cir. 1975). Plaintiffs may also satisfy the monetary requirement when it is viewed from the standpoint of future medical assistance payments. Cf. *Moore* v. *Betit*, *supra* at 1006.

16. Although the Supreme Court has left open the issues of whether all supremacy clause and § 1983 claims are cognizable under 28 U.S.C. §§ 1343(3) and/or (4), the Second Circuit has, at least temporarily, resolved those same issues against jurisdiction. See *Andrews* v. *Maher*, *supra*.

17. See, e.g., *Hagans* v. *Lavine*, *supra* at 543-45; *Cordova* v. *Reed*, Docket No. 75-7120 at 5469 (2d Cir. August 7, 1975).

    Plaintiffs stated at oral argument that they would move to convene a three-judge court if the motion for summary judgment on their "statutory" claim is denied.

18. While the crux of plaintiffs' attack is on subdivision (1) of § 248.3(c), subdivision (2) is, in all strictness, more directly relevant since its concern is how much of a medically needy family's income can be "taken" to defray the costs of medical assistance. Subdivision (1) concerns itself with levels of income for eligibility purposes. None of the members of the class are complaining that they are not eligible for medical assistance because of unlawful income levels. Thus, subdivision (1) is only derivatively relevant to plaintiffs' case; that is, to construe "established level" in subdivision (2) requires

interpreting subdivision (1) to see if the established level comports with the minimum requirements there.

19. "The following income • • • shall be exempt and shall neither be taken into consideration nor required to be applied toward the payment or part payment of the cost of medical care and services • • •. (8) income in an amount set forth in the following schedule:

> "Annual net income—Number of family members in a household and family members for whom they are legally responsible or have assumed responsibility

One	Two	Three	Four	Five	Six	Seven
$2,500	$3,400	$4,000	$5,000	$5,700	$6,400	$7,200
[$2,700]	[$3,800]	[$4,200]	[$5,000]	[$5,800]	[$6,500]	[$7,400]

> "Such income exemptions shall be increased by six [seven] hundred dollars for each member of a family household in excess of seven."

Figures in brackets show the amount of exempt income as of October 1, 1975, to reflect recent amendments of § 366(2)(a)(8).

20. The same income allowances specified in NYSSL § 366(2)(a)(8) appear in this regulation, which dictates how much of the "excess income" of a person in a medical institution can be "given" to his family for maintenance expenses. This is the relevant section when the medically needy family's income falls short of the allowance level and the hospitalized member of the family has income to contribute to the family.

21. Again, the same income allowances appear in this regulation as those specified in NYSSL § 366(2)(a)(8). This regulation, rather than § 360.5, applies when the spouse of a hospitalized person has income in excess of the income allowance level. Any income in excess of the appropriate level is to be contributed to the medical expenses of the hospitalized member. NYCRR § 360.7(a)(5).

The overall effect of NYSSL § 366(2)(a)(8) and NYCRR §§ 360.5 and 360.7 is to set the level of maintenance income that a medically needy family is allowed to live on.

22. Thus, for example, a family of two with a net available income of $3,500 and medical expenses of $99 would not be eligible for medical assistance because their income exceeds the $3,400 level specified in the statute and regulations. Another family of two with net available income of $5,000 and medical expenses of $5,000 would be allowed to retain $3,400 for maintenance expenses and required to contribute the remaining $1,600 to the cost of medical assistance.

23. The defendants maintain that for a family of two, the payment standard under SSI (a flat grant system) is higher than the "ADC payment standard" (the standard computed under defendant's averaging methodology discussed below). Because the court rejects defendants' route to an assertedly valid ADC payment standard, and it is conceded that a family of two living in Rockland County and paying the same rent as plaintiffs would receive more under ADC than under the SSI program, the ADC program has the higher payment standard. For the remainder of this discussion, therefore, the amount of ADC payments will be considered the higher payment standard.

24. In some States, only a specified percentage of a family's standard of need is actually paid. See *Rosado* v. *Wyman*, 397 U.S. 397, 408-09 (1970). In New York, 100% of the standard of need is paid out in benefits. Thus, the standard of need and the payment standard are identical in New York's ADC program. See NYSSL § 131-a(3).

25. "The following schedule shall be the standard of monthly need for determining eligibility for all categories of assistance in and by all social services districts:

Number of Persons in Household

One	Two	Three	Four	Five	Six
$94	*$150*	*$200*	*$258*	*$318*	*$368*

> "For each additional needy person in the household there shall be added an additional amount of fifty dollars monthly.
>
> "In addition to the above, the standard of need shall include amounts for shelter and fuel for heating • • •."

NYSSL § 131-a(2).

26. Id.

27. "A State plan for medical assistance must—• • • include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which • • • are consistent with the objectives of this subchapter • • •." 42 U.S.C. § 139a(a)(17).

28. See note 39 *infra.*

29. To be sure, an eligibility standard entailing cumbersome calculations and lengthy investigations would be out of step with the simplification philosophy of 42 U.S.C. § 1396a(a)(17) and 45 C.F.R. § 248.3(c)(1). But the ADC methodology is not such a standard. A family's shelter cost, up to the appropriate county maximum, can be ascertained with fair ease. As shown by the State's Budget Worksheet for Medical Assistance Form DDS 517), each social service district must review and verify each claimant's assets and income before passing on his eligibility. Having applicants list their shelter costs and investigating the listed amount should not substantially increase the administrative task. Cf. *Shapiro* v. *Thompson,* 394 U.S. 618, 636 (1969).

30. See 2 CCH Medicare and Medicaid Guide ¶ 15,600, at 6558 (Michigan's medical assistance eligibility standard is expressed as a formula).

31. The federal ADC eligibility regulations requires that the eligibility standard be expressed in "money amounts." 45 C.F.R. § 233.20(a)(2). New York obviously did not view this language as a bar to setting up a variable ADC standard as evidenced by NYSSL § 131-a.

32. Plaintiffs contend that the income levels in NYSSL § 366(2)(a)(8) do not accurately reflect statewide shelter allowances even as increased effective October 1, 1975. The parties were to proceed to discovery on this issue if the court denied plaintiffs' summary judgment motion.

33. The parties do note cite, and the court has not found, any direct learning on the intended meaning of the phrase "generally used." We do know that an early draft of 45 C.F.R. § 248.3(c)(1) did not contain the "generally used" language at all. The draft specified that the medical assistance eligibility standard was to be, "as a minimum, at the level of the payment standard used as a measure of financial eligibility in the appropriate money payment program • • •." 38 Fed. Reg. 32219 (1973). The "generally used" language was added in response to comments that the draft language incorrectly implied that separate standards governed the aged, blind and disabled and families with dependent children. 39 Fed. Reg. 9512 (1974). The evolution of the phrase defendants invoke further demonstrates, if it is necessary, the fallaciousness of their reasoning from it.

34. Many States, including New York, pay some welfare recipients more than the amount dictated by the generally applied payment standard for unusual or "special" expenses. See, e.g., NYSSL § 131-a(6).

35. Certain individuals who received aid under Titles I, X, XIV, or old XVI of the Social Security Act as of December 1973, were deemed to be eligible for SSI payments, notwithstanding incomes or resources exceeding the new eligibility level under SSI. 42 U.S.C. § 1382(g).

36. 45 C.F.R. § 248.21(a)(3)(i)(B) still applies to Puerto Rico, Guam, and the Virgin Islands.

37. See, e.g., *Almenares* v. *Wyman,* 334 F. Supp. 512 (S.D.N.Y.), aff'd 453 F.2d 1075, 1087 (2d Cir. 1971), cert. denied, 405 U.S. 544 (1972); *Rosado* v. *Wyman,* 397 U.S. 397, 406 (1970).

38. The HEW Compliance Report for the Quarter ending March 31, 1975, contains the following section:

"Medical Services Program	*Medically Needy Level*
45 CFR 248.3(c)(1)(ii)(B)(2) Section 1903(f)(1)(B)(i) SSA	Due to a series of factors, the cash assistance stnds. have become more liberal than the MA standards for most family sizes."

It is conceivable that HEW's criticism merely relates to the fact that New York's medical assistance standards have become too low in view of the gradual increase in shelter allowances under the cash assistance programs. Thus it may be that HEW is calling for an updating of the levels set in NYSSL § 366(2)(a)(8).

39. 42 U.S.C. § 1396a(10)(c)(i) arguably provides additional statutory authority for 45 C.F.R. § 248.3(c). See *Dominguez* v. *Milliken, supra* at 9119-21.

40. Referring to the "reasonable standards" language, the Report of the House Ways and Means Committee states in part:

> "• • • the State plan must include such safeguards as may be necessary to assure that eligibility • • • will be determined • • • in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have

> the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance. • • • Under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation • • •."

H.R. Rep. No. 213, 89th Cong., 1st Sess. 66 (1965).

41. The following passage indicates that Congress intended that the medically needy not be forced to live below the applicable public assistance subsistence level:

> "In no event • • • may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance."

S. Rep. No. 404, 1 U.S. Code Cong. & Admin. News 1943, 2019 (1965). See also HEW Handbook of Public Assistance Administration, Supp. D. § D-4240 (A)(2)(1966).

42. See, e.g., *Haberman* v. *Finch*, 418 F.2d 664, 667 (2d Cir. 1969); *Gold* v. *HEW*, 463 F.2d 38, 41 (2d Cir. 1972).

43. See these observations in the course of hearings on Medicaid legislation by George K. Wyman, a former New York Commissioner of Social Services:

> "The major cause of dependency in the United States is illness. Everyone agrees that the 'poorest of the poor,' those who receive public assistance, should have their medical care needs met. Also, most people believe we should prevent dependency if at all possible. Therefore it makes good, common sense to help those persons who are able to support themselves with food, clothing, and shelter but who need assistance with their medical care bills. This means we should help the workingman who is faced with a sizable medical bill, in order that he will not have to mortgage his home, sell his car, or go into debt, in order to pay the medical obligation, or, even worse, deplete himself of his resources to the point where he becomes a welfare recipient."

Hearings on H.R. 12080 Before the Senate Finance Committee, 90th Cong., 1st Sess., pt. 3, at 1547 (1967).

Order and Judgment of the District Court, Appendix C.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

75 Civ. 1224

M.E.F.

MARION AITCHISON, et al.,

Plaintiffs,

against

STEPHEN BERGER, et al.,

Defendants.

This cause having come to be heard on plaintiffs' motion for summary judgment under F.R.C.P. 56 on their third claim, as amended, alleging that New York Social Services Law § 366(2)(a)(8) and 18 New York Codes, Rules, and Regulations §§ 360.5(e) and 360.7(a)(5) are inconsistent with 45 C.F.R. § 248.3(c)(1)(ii) and therefore invalid and for a class action order under F.R.C.P. 23; and on defendants' motion to dismiss the action under F.R.C.P. 12(b)(1) and (6) for want of a substantial constitutional question and, in the alternative, for summary judgment in their favor under the F.R.C.P. 56 on plaintiffs' third claim, as amended; and the Court having considered the pleadings, affidavits, stipulations, and memoranda of law submitted by the parties; and the Court having heard oral argument; and after due deliberation, having filed its opinion on November 12, 1975, it is

ORDERED that defendants' motions to dismiss for want of a substantial constitutional question, and, in the alternative,

for summary judgment in their favor on plaintiffs' third claim, as amended, be and the same hereby are denied; and it is further

ORDERED that plaintiffs' motion for a class action order under F.R.C.P. 23 be and the same hereby is granted, said class to consist of all applicants for and recipients of medical assistance only who by reason of the application of New York Social Services Law § 366(2)(a)(8) and 18 NYCRR §§ 360.5(e) and 360.7(a)(5), retain less monthly exempt income than the standard of need for families of the same size, paying the same shelter cost (plus cost of fuel where applicable) and living in the same social services district who have qualified for categorical public assistance under the Aid to Families with Dependent Children program; and it is further

ORDERED that plaintiffs' motion for summary judgment be and the same hereby is granted to the extent hereinafter set forth; and it is further

ORDERED, ADJUDGED AND DECREED that 45 C.F.R. § 248.3(c)(1)(ii), as affixed to the class herein, is declared consistent with 42 U.S.C. §§ 1396a(a)(17) and § 1396a (10)(c)(i) and therefore valid; and it is further

ORDERED, ADJUDGED AND DECREED that New York Social Services Law § 366(2)(a)(8) and 18 NYCRR §§ 360.5(e) and 360.7(a)(5) are declared inconsistent with 45 C.F.R. § 248.3(c)(1)(ii) and therefore invalid as applied to the class; and it is further

ORDERED that defendants, their officers, agents, employees and successors in interest be and they hereby are permanently enjoined from enforcing New York Social

Services Law § 366(2)(a)(8) and 18 NYCRR §§ 360.5(e) and 360.7(a)(5) against the class so as to permit said individuals to retain less monthly exempt income than the standard of need for families of the same size, paying the same shelter cost (plus cost of fuel where applicable) and living in the same social services district who have qualified for categorical public assistance on the Aid to Families with Dependent Children program; and it is further

ORDERED that the retained exempt income of class members shall be recomputed in conformity with the provisions of this Order and Judgment within 25 days from the entry hereof; and it is further

ORDERED that defendant Stephen Berger, Commissioner of the New York State Department of Social Services, or the officers or employees of said Department shall transmit to the Commissioners of all social services district within the state instructions to conform with the provisions of this Order and Judgment within 10 business days after the entry hereof.

Dated: New York, New York, December 3, 1975.

MARVIN E. FRANKEL

Stipulation Modifying Order and Judgment of the District Court, Appendix D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STIPULATION

75 Civ. 1224

MARION AITCHISON, individually and on behalf of MICHAEL AITCHISON, and JANICE AITCHISON, her children, and on behalf of all other persons similarly situated,

Plaintiffs,

against

STEPHEN BERGER, individually and as Commissioner of the Department of Social Services of the State of New York, and NOAH WEINBERG, individually and as Commissioner of the Department of Social Services of Rockland County, New York,

Defendants.

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties to the above captioned action that:

1. The Order and Judgment entered by the District Court on December 3, 1975 be and the same hereby is amended and modified by deleting from the seventh decretal paragraph the number "25" and inserting instead the number "75," said decretal paragraph, as amended and

modified, to state as follows:

> "ORDERED that the retained exempt income of class members shall be recomputed in conformity with the provisions of this Order and Judgment within 75 days from the entry hereof; and it is further"

2. The 75 day period described in the seventh decretal paragraph of the Order and Judgment of the District Court, amended and modified as set forth in ¶ 1 above, shall start on December 3, 1975 and shall continue thereafter provided however that the running of said 75 day period shall be tolled by the issuance of any stay (or stays) in defendant's favor and the tolling of said 75 day period shall continue for the duration of said stay (or stays). The commencement of the 75 day period on December 3, 1975 is without prejudice to defendant's application to the district court to extend or otherwise modify said period in the event he does not prevail on the merits of his appeal(s) and/or that a stay (or stays) are not issued to protect the *status quo* as it existed prior to the entry of the Order and Judgment on December 3, 1975 (subject to the exception in favor of the named plaintiffs described in the affidavit of Judith A. Gordon, sworn to December 10, 1975, and filed on defendant's behalf in the United States Court of Appeals for the Second Circuit).

3. In the event the defendant does not prevail on his appeal(s) from the Order and Judgment of the District Court, he recognizes that his obligation to establish exempt income levels for medical assistance only recipients in conformity with said Order and Judgment arises as of December 3, 1975.

Stipulation Modifying Order and Judgment of the District Court, Appendix D.

4. A Stipulation containing the same substantive provisions shall be executed and filed in the United States Court of Appeals for the Second Circuit.

Dated: New York, New York
December 15, 1975

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Stipulation Modifying Order and Judgment of the District Court, Appendix D.

Louis J. Lefkowitz
Attorney General
By:

Judith Gordon
Judith A. Gordon
Assistant Attorney General
Attorney for Defendant Berger
Two World Trade Center
New York, New York 10047

So ordered December 22, 1975.

Marvin E. Frankel
U.S.D.J.

Program Instruction APA-PI-74-17, HEW 1974, Appendix E.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

PROGRAM INSTRUCTION
APA-PI-74-17
June 10, 1974

TO: STATE AGENCIES ADMINISTERING APPROVED PUBLIC ASSISTANCE PLANS

SUBJECT: Consolidated Standards — Cost Differentials

CONTENT: 45 CFR 233.20(a)(2) provides that a State plan for OAA, AFDC, AB, APTD, or AABD must "specify a statewide standard, expressed in money amounts, to be used in determining the need of applicants and recipients and the amount of the assistance payment."

Federal policy further provides that by July 1, 1969, the State's standard of assistance for the AFDC program must have been adjusted to reflect fully changes in living costs since such standards were established and any maximums imposed by the State on the amount of aid paid to families must have been proportionately adjusted.

In such adjustment, a consolidation of the standard (i.e., combining items) may not result in a reduction of the content of the standard. Furthermore, the State must provide that the standard will be uniformly applied throughout the State.

Program Instruction APA-PI-74-17, HEW 1974, Appendix E.

The provisions in section 402(a)(1) of the Social Security Act provide the basis for the requirement of a single statewide standard of assistance. However, area differentials are permissible when there is objective, verifiable evidence that the differences are appreciable and based on actual differences in costs.

The Supreme Court in *Wyman* v. *Boddie,* 402 U.S. 991 (1971), affirmed without opinion; 434 F. 2d 1207 (1970), upheld the Department of Health, Education, and Welfare position that objective justification must be provided for such differentials. The principle has been further enunciated in several lower court cases.

In *Rothstein* v. *Wyman,* 398 U.S. 275 (1970), affirmed on other grounds; 303 F. Supp. 339 (1969), as well as in *Boddie,* the decisions emphasized that there must be objective, verifiable evidence that the differentials
[2] are based on actual differences in costs. In *Rothstein,* the Court found no evidence justifying any disparity in the levels of schedules between New York City and the surrounding counties.

In *Boddie,* the Court noted that, with the exception of shelter and to a lesser degree utilities, variable cost differences between recipients similarly situated have not been shown to exist in New York State. With regard to cost studies conducted in May 1968 by the State, the Court stated:

"that the only variation in costs between these areas was due to slight differences in utility

Program Instruction APA-PI-74-17, HEW 1974, Appendix E.

rates. Every study undertaken by the Department since then has confirmed the initial conclusion that, with respect to the items covered by the basic grant, that is, food, clothing and personal care, home furnishings, household operations, transportation, education, and miscellaneous items, there are no objectively verifiable differences in cost."

To determine whether there are appreciable differences, the actual costs as determined by objective data must be sufficiently different when compared with the State's standard to meet the Court's test of "appreciable." If there are to be differentials, States are encouraged to limit such justifiable differentials to two or three.

Unless "appreciable" cost differences can be shown by objective data to exist, States utilizing non-uniform standards violate section 402(a)(1) of the Social Security Act and 45 CFR 233.20(a)(2) which require a single statewide standard of assistance.

INQUITIES
To: SRS Regional Commissioners

s/
Commissioner
Assistant Payments Administration

Guidelines for Development of Consolidated AFDC Assistance Standards (Excerpts), HEW 1974, Appendix F.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Assistance Payments Administration
September 1974

Preface

This manual is intended to be used by State welfare agencies to familiarize and assist them in development of consolidated standards of assistance for the Aid to Families with Dependent Children (AFDC) Program. In a step-by-step approach, the fundamentals of project management are emphasized. Explanation of the objectives of each chapter precedes suggested tasks and discussion of the work they involve. Additionally, each chapter details documentation requirements to facilitate HEW regional office review of proposed consolidation plans.

While this manual provides an approach with various options to consolidation of standards of assistance, it is not intended to be used as a definitive guide. The purpose of its publication is to provide State Administrators a description of the process of consolidation.

The approaches contained herein are not the only methods that can be used, but they have been used effectively by several States.

It is hoped that this document will provide the reader with an insight to the process and procedures of consolidation and will assist States in adopting this equitable method of distribution of scarce resources to those who are most in need.

I would like to take this opportunity to express my appreciation for the contribution made by the late Richard M. Gertzof of American Data Systems, Inc. Without his initiative and long hours of work, this document would not have been prepared.

John A. Svahn
John A. Svahn

Introduction [i-1]

A. Consolidated Standard Defined

A consolidated standard of assistance is a redefinition of a State's AFDC standards from individual items or groups of items to a single standard which is expressed in a dollar amount per recipient or per recipient family. This redefinition is accomplished by averaging payments for the individual items using a statistically fair method and combining these averages into a consolidated standard.

Specifically, the averaging and consolidation process may promote:

(1) Elimination of one or several special needs in the agency standard through incorporation into a consolidation figure;

(2) Redefinition of a shelter standard and its qualifications into a flat amount per recipient or recipient family by "averaging away" the differences caused by such situations as subsidization by public housing, provision of free housing, or prorating of shelter costs between recipients and non-recipients in a household;

(3) Redefinition of specific differentials such as geographic location, ages and sex of children, or other individual factors, into flat amounts on a per recipient or a recipient family basis.

A properly executed consolidation based on fair averaging principles will reasonably represent the statewide application of needs determination as were formerly decided by assistance payments workers on an individual basis. Furthermore, fair averaging will assure recipients an equitable distribution of funds budgeted for all items in the State's standards of assistance.

B. Rationale for a Consolidated Standard

Many States have discovered that there are considerable difficulties in administering an AFDC public assistance program based on a determnation of individual needs. Problems encountered include:

[i-1]

(1) A complicated standards structure which attempts to explicitly relate, the amounts of the payments to the individual circumstances of the recipient;

(2) The inadequacy of the standards structure;

(3) The greater chance of error in calculating detailed budget computation and in misinterpreting State policies which result in higher error rates;

(4) Additional paperwork and staff time administering a more complex budget system;

(5) Inequities in amounts of assistance among families in similar socioeconomic situations.

[i-2] Conversion to a consolidated standard controls many of these difficulties:

(1) All recipients in similar situations are eligible for the same level of financial need and are treated on an equitable basis.

(2) The consolidated standards of assistance is amenable to updating as costs of living change, permitting a State to adjust recipients' grants on a more timely basis.

(3) The variations by case technicians in interpreting and applying policy are reduced.

(4) Consolidated standards are adaptable to computer calculation of grants which speeds up grant delivery and reduces administrative error.

(5) The error ratio of overpayments and underpayments due to incorrect budgeting of basic and special needs generally declines for those standards consolidated.

[i-2]

C. Legal Authority and Background

The enactment of Section 402(a)(23) of the Social Security Act in 1967 is a milestone, in that prior to its passage, States were traditionally at liberty to decide the levels of standards of needs and payment for public assistance. This is illustrated by the vast differences in the types and levels of standards in existence. Some States include items in their basic required standards that other States do not recognize at all. A few States pay 100% of need; others impose dollar maximums to an individual or family; still others scale payments by ratable reductions of a fixed percentage of the need standard.

Section 402(a)(23) reads as follows:

> "(The States shall) provide that by July 1, 1969, the amounts used by the State to determine needs of individuals will have been adjusted to reflect fully changes in living costs since such amounts were established and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted."

Federal regulations in support of Section 402(a)(23) incorporated HEW interpretation and imposed certain requirements on State AFDC plans. Among the most

important tenets of 45 CFR 233.20(a) are that the States:

"Provide that the determination of need and the amount of assistance for all applicants and recipients will be made on an objective and equitable basis and all types of incomes will be taken into consideration in the same way except where otherwise specifically authorized by Federal statute.

[i-3]

"Specify a statewide standard, expressed in money amounts, to be used in determining (a) the need of applicants and recipients and (b) the amount of the assistance payments.

"(The State Plan must) provide that by July 1, 1969, the State's standard of assistance for the AFDC program will have been adjusted to reflect fully [i-3] changes in living costs since such standards were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted. In such adjustment a consolidation of the standard (i.e., combining of items) may not result in a reduction in the content of the standard. In the event the State is not able to meet need in full under the adjusted standard, the State may make ratable reductions in accordance with subparagraph (3) (viii) of this paragraph (if full payments are precluded by maximums or insufficient funds, adjustments will be made by methods applied uniformly statewide). Nevertheless, if a State maintains a system of dollar maximums, these maximums must be proportionately adjusted in relation to the updated standards."

"Provide that the standard will be uniformly applied throughout the State."

"If the State agency includes special need items in its standard, (a) describe those that will be recognized, and the circumstances under which they will be included, and (b) provide that they will be considered in the need determination for all applicants and recipients requiring them."

It was not until the United States Supreme Court decided *Rosado* v. *Wyman* in April 1970 that the provisions of 402(a)(23) were tested and explicitly interpreted. In *Rosado* the Supreme Court ascribed two broad purposes to Section 402(a)(23), the first being that States "face up realistically to the magnitude of the public assistance requirement and lay bare the extent to which their program fell short of fulfilling actual need", and the second, that they "apportion their payments on a more equitable basis."

The Court recognized that Section 402(a)(23) would still allow a State, "after recomputing its standard of need, (to) pare down payments to accommodate budgetary realities by reducing the percent of benefits paid or switching to a percent reduction system, but it may not obscure the actual standard of need."

The decision further reiterated that the Congressional intent was not for Section 402(a)(23) to be a meaningless exercise, and that States could not redefine their standards of assistance to circumvent the requirements of re-evaluating their existing standards. This precluded a State from reviewing its standards and then applying an update and percentage reduction in such a way that both the standards and payment made remained unchanged.

The Court concluded that Section 402(a)(23) invalidated "any program that substantially alters the content of the standard of need in such a way that it is less than it was prior to the enactment of 402(a)(23), unless a State

can demonstrate that the items formerly included no longer constituted part of the reality of existence for the majority of welfare recipients. (The Court did not) hold that (States) may not, consistently with the Federal statutes, consolidate items on the basis of statistical averages. Obviously, such averaging may affect some families adversely and benefit others. Moreover, it is conceivable that the net payout, assuming no change in the level of benefits, may be somewhat less under a streamlined program. Providing all factors in the old equation are accounted for and fairly valued and providing the consolidation on a statistical basis reflects a fair averaging, a State may, of course, consistently with 402(a)(23) redefine its method for determining need. A State may, moreover, as (the Court) noted, accommodate any increase in its standard by reason of 'cost-of-living' factors to its budget by reducing its level of benefits."

Based on the Supreme Court's interpretation of 402(a)(23), procedures are clearly defined for establishing reasonable AFDC standards within the States. Furthermore, it establishes a basis for guidelines for redefinition and consolidated standards of assistance. In general terms, any consolidation of AFDC standards must provide accountability for each consolidated item with confirmation that it has been averaged appropriately.

Some of the specific requirements and criteria of a consolidation plan are the following:

(1) Consolidation must be based on standards of assistance that have been updated by July 1, 1969;

(2) Consolidation must not result in overall reduction in the content of the existing standard;

(3) The new standard must be applied equally and objectively to applicants and recipients alike;

(4) A consolidated standard must be a statewide standard; and, therefore,

(5) It must be uniformly applied throughout the State.

D. This Manual's Approach to Consolidation of AFDC Standards of Assistance

The purpose of this manual is to meet the objectives of developing a consolidated standard of assistance based upon this legal framework.

The following steps outline the general development and implementation:

(1) Review the State standards of assistance, including policy manuals, State plan material, and applicable Federal laws and regulations;

(2) Understand the method of initiating and authorizing of grant payments;

(3) Identify each component of the State assistance standard and payments made, noting the history and evolution of standards;

(4) Review and evaluate the State procedures for updating standards in accordance with Section 402(a)(23), and update those standards of assistance as required;

(5) Obtain HEW approval of proposed updating methodology;

(6) Determine which items are to be incorporated into the consolidated standard, those which are to be paid outside of the consolidated standard, and those which may legally be deleted from policy;

(7) Design a statistical approach for surveying case records as a basis for developing fair averages;

(8) Survey the necessary cases, updating standards where required;

(9) Tabulate the results and determine their statistical validity;

(10) For those standards to be updated on a percentage basis after surveying, apply percentage averages to arrive at updated consolidated standards for each recipient or recipient family;

(11) Prepare analytical and financial reports reviewing the potential effect on recipients' budgets and on agency finances under alternative situations;

(12) Prepare required administrative changes including development of policy and plan material, informational material, procedures, and forms;

(13) Obtain HEW approval of plan material;

(14) Implement the consolidated standards of assistance.

This manual is intended to guide the State agency in designing a consolidated standard of assistance that will meet the legal requirements and be responsive to its recipients' needs as well as its own.

E. Format

All definable phases are examined in depth. Each chapter is a separate entity which explores the subject and may serve as a guide for the necessary tasks.

Generally, each chapter is divided into four or more basic sections. The first states the objectives and their significance. The second section suggests the tasks for meeting the given objectives. This list of task descriptions comprises the work program for the chapter. Because the

manual is intended for use by different States, the work program may, on occasion, appear somewhat broad in scope. Therefore, the State should examine it with regard to its own unique situation.

Section three supplements the work program with particular elaboration on major tasks and suggested approaches. Section four of each chapter is included as a discussion of documentation requirements of each work program step. This section describes the format and content of completed work which may be requested for review by the HEW regional office.

Additional sections of the manual are included as appropriate to describe special situations or to clarify the segments of the chapter.

Supreme Court, U. S.
FILED
SEP 20 1976
MICHAEL RODAK, JR., CLERK

No. 75-1447

In the Supreme Court of the United States

OCTOBER TERM, 1976

STEPHEN BERGER, individually and as COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES OF THE STATE OF NEW YORK, PETITIONER

v.

MARION AITCHISON, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

ROBERT H. BORK,
Solicitor General,
Department of Justice,
Washington, D.C. 20530.

WILLIAM H. TAFT, IV,
General Counsel,

SARAH WILLIS WILCOX,
Attorney,

Department of Health, Education, and Welfare,
Washington, D.C. 20201.

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In the Supreme Court of the United States

OCTOBER TERM, 1976

No. 75-1447

STEPHEN BERGER, individually and as COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES OF THE STATE OF NEW YORK, PETITIONER

v.

MARION AITCHISON, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

This memorandum is submitted in response to the Court's invitation to the Solicitor General to file a brief expressing the views of the United States.

QUESTIONS PRESENTED

As part of its procedure for determining eligibility of the "medically needy" for participation in the program of Medical Assistance ("medicaid") established by Title XIX of the Social Security Act, 42

U.S.C. (and Supp. V) 1201 *et seq.*, the State of New York has established income exemption levels, for a large percentage of applicants, which are lower than the levels of payment standards it uses in its program of Aid to Families with Dependent Children under Title IV of the Act, 42 U.S.C. (and Supp. V) 601 *et seq.*

The United States will discuss the questions whether this aspect of New York's method of determining eligibility for and extent of medicaid assistance conflicts with regulations (45 C.F.R. 248.3(c)) of the Department of Health, Education, and Welfare under Title XIX of the Social Security Act and, if so, whether those regulations are consistent with the Act.

STATEMENT

1. Title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. (and Supp. V) 1396 *et seq.*, creates a Medical Assistance program, commonly known as "medicaid," pursuant to which the states, with federal funds, may reimburse the costs of medical treatment provided to the "categorically needy," *i.e.*, those persons who receive payments under the cash assistance programs of the Social Security Act,[1]

[1] The present categorical assistance programs are the Aid to Families with Dependent Children (AFDC) program (Title IV of the Act, 42 U.S.C. (and Supp. V) 601 *et seq.*), the Supplemental Security Income (SSI) program (Title XVI of the Act, 42 U.S.C. (and Supp. V) 1381 *et seq.*), and (in Guam, Puerto Rico and the Virgin Islands) the programs of aid to the aged, blind, and disabled (Titles I, X, XIV, and XVI of the Act, 42 U.S.C. (and Supp. V) 301 *et seq.*, 1201 *et seq.*, 1351 *et seq.*, and 1381 *et seq.*).

and, if a participating state so chooses, to the "medically needy," *i.e.*, those individuals whose income and resources exceed the amounts allowed to the categorically needy but which are insufficient to cover the costs of necessary medical care and services. 42 U.S.C. (Supp. V) 1396a(a)(10)(A) and (C); 45 C.F.R. 248.1(a)(1) and (2).[2] If a state elects to extend medicaid coverage to the medically needy, its plan must include all individuals within that category and must offer each such person medical assistance equal in amount, duration and scope. 42 U.S.C. (Supp. V) 1396a(a)(10)(C)(i) and (ii). Thirty-two of the 54 jurisdictions participating in Title XIX, including New York (see N.Y. Social Services Law (N.Y.S.S.L.) 366(1) (McKinney 1976)), have chosen to extend medicaid coverage to the medically needy.

States offering medicaid coverage to the medically needy are accorded a range of discretion in fixing the amount of income an assisted family may retain to meet normal living expenses. To qualify for federal matching funds, the state may set that amount at not more than 133⅓ percent of the state's highest AFDC payment for a family of the same size without income or resources (42 U.S.C. 1396b(f)(1)(B)(i)), and at not less than "the higher of the levels of the payment standards generally used as a meas-

[2] See *Fullington* v. *Shea*, 320 F. Supp. 500 (D. Colo.), affirmed, 404 U.S. 963; *Freeman* v. *Parham*, 475 F.2d 185, 187 (C.A. 5).

ure of financial eligibility in the [categorical assistance] programs." 45 C.F.R. 248.3(c)(1)(ii).[3]

2. New York utilizes a two-step process to calculate the standard of need under its AFDC program:[4] for each recipient of categorical assistance under Title IV, the state includes (a) a flat amount, varying only according to family size, to cover all basic subsistence needs except shelter, and (b) a separate "shelter allowance." N.Y.S.S.L. 131-a(2); 18 N.Y.C.R.R. 352.3(a). The shelter allowance is determined by including the family's actual shelter costs up to a specified maximum amount for each of the State's 58 social services districts (Pet. 15; Pet. App. 9a-10a).

For the medically needy, however, New York computes medicaid eligibility in a different manner. As with the categorically needy, medicaid eligibility for these families is in part determined by reference to

[3] All parties agree that the relevant categorical assistance program in this case is the AFDC program. See Pet. 9, 15-16; Br. in Opp. 6; Pet. App. 9a, 19a, n.23.

[4] Although the states are required to establish "standards of need" under their AFDC program, these standards may be above the amounts actually paid. See *Rosado* v. *Wyman*, 397 U.S. 397, 408-409. Since it is a state's actual payment level for the categorically needy that determines the medicaid minimum income eligibility level for the medically needy (42 U.S.C. (Supp. V) 1396a(a)(10)(A)), 45 C.F.R. 248.3(c)(1)(ii) refers to "payment standards" rather than "standards of need." In any event, because New York pays AFDC benefits equal to 100 percent of its standard of need, the State's AFDC standard of need and payment standards are the same (Pet. App. 19a, n. 24). See N.Y.S.S.L. 131-a(2) and (3).

the basic flat grant payable to an AFDC family of the same size. But instead of adding to this amount a shelter expense equal to the family's actual rent (up to a maximum depending on locality), New York includes a uniform shelter allowance, calculated by averaging the shelter allowances paid to all AFDC families of comparable size throughout the State (Pet. 15-16; Pet. App. 5a-6a). N.Y.S.S.L. 366(2)(a)(8). Thus, except for the few medically needy families whose actual rent equals the statewide hypothetical shelter cost of an average AFDC family of comparable size, New York's method of determining medicaid eligibility ensures a discrepancy between the amount of maintenance income which a medically needy family is allowed to retain and the amount the family would be paid under the AFDC program if it were without any income.

3. Respondents are the wife and child of a disabled 54-year-old man who has been in a nursing home since 1972 (Pet. App. 4a). Their monthly income is $368.39 (Pet. 8). As a family of two,[5] under New York's method of determining medicaid eligibility they are entitled to assistance only after contributing $51.39 monthly toward the cost of George Aitchison's nursing home care, thereby reducing the amount of income available for their living expenses to $3,800 annually, or $317 monthly.

[5] For purposes of determining family size for medicaid eligibility, New York regulations provide that a family member in chronic care "shall not be deemed to be a member of any household" (Pet. App. 16a, n. 8). 18 N.Y.C.R.R. 360.5(e).

N.Y.S.S.L. 366(2)(a)(8). Under New York law, however, the monthly standard of need for an AFDC family of comparable size, paying the same rent and living in the same county as respondents, would be $370—the $150 basic subsistence allowance (N.Y. S.S.L. 131-a(2)) plus respondents' actual rent ($250) up to the specified ceiling of $220 for Rockland County (Pet. App. 5a). If the amount they could retain for themselves had been set at $370 per month, respondents would have been entitled to participate in the medicaid program without making a contribution to the cost of the nursing home care.

In March 1975, respondents instituted this action for declaratory and injunctive relief in the United States District Court for the Southern District of New York, contending that New York's statutes and regulations for determining minimum income levels for medicaid eligibility by the medically needy were in conflict with the Equal Protection Clause of the Fourteenth Amendment, Title XIX of the Social Security Act, and federal regulations under the medicaid program.

The district court certified the suit as a class action [6] and, pursuant to this Court's directions in *Hagans* v. *Lavine*, 415 U.S. 528, 543-545, addressed

[6] The district court defined the class represented by respondents as "all medically needy persons in New York who are required by [petitioner], pursuant to state statute and regulations, to live on a monthly income allowance which is below the level of need for categorical assistance families of the same size, living in the same county, and paying the same rent" (Pet. App. 7a).

respondents' statutory contentions before considering whether a three-judge district court was required to pass upon the constitutional claims. The court then held that New York's method of using *average* statewide shelter costs in fixing minimum income levels for medicaid eligibility by the medically needy, while at the same time using a family's *actual* shelter costs in setting AFDC standards of need, allowed the medically needy income eligibility level in certain cases to be set below the highest "payment standards generally used" in the State's categorical assistance program, in violation of 45 C.F.R. 248.3(c)(1)(ii) (404 F. Supp. 1137; Pet. App. 3a-21a). The court also held that the federal regulation was consistent with Title XIX, since it furthered the legislative goal of helping individuals not receiving general cash assistance cope with catastrophic medical expenses without having to impoverish themselves below the level of the categorically needy. N.Y.S.S.L. 366(2)(a)(8) and its implementing regulations were therefore declared invalid and petitioner was enjoined from enforcing them against respondents (Pet. App. 23a-25a). See *King* v. *Smith*, 392 U.S. 309, 333, n. 34. The court of appeals affirmed on the opinion of the district court (Pet. App. 1a-2a).[7]

DISCUSSION

The principal question presented in this case is whether New York may use a maximum income re-

[7] On April 19, 1976, this Court declined to stay the court of appeals' judgment pending a petition for a writ of certiorari.

tention level for medicaid recipients that may be significantly less than "the higher of the levels of the payment standards generally used as a measure of financial eligibility [for categorical assistance]." 45 C.F.R. 248.3(c)(1)(ii). In our view, the district court correctly determined that New York is precluded from utilizing a maximum income retention level which is based on an average shelter allowance when the State's relevant categorical assistance payment standard is based on a family's actual shelter costs, which often exceed the average allowance. Because of the disparity in the State's standards for the categorically and medically needy, respondents are required to contribute to the payment of health costs even though their protected income maintenance level may be lower than that of recipients of categorical assistance—a result that is at odds with the legislative intent of Title XIX. See 42 U.S.C. (Supp. V) 1396a(a)(10)(C) and (a)(17). Since the result reached below is correct and is in accord with the decisions of other courts, and since few if any other state medicaid plans suffer the defect found in New York, this case presents no issue warranting review.

1. From the inception of the Medical Assistance program in 1965, Congress has recognized that a large segment of the American people are not qualified for or in need of general or "categorical" assistance to meet their day-to-day expenses but nonetheless require financial aid because of substantial medical burdens. In defining the "medically needy" for purposes of medicaid eligibility, Congress characterized

the group as "less needy" than recipients of categorical assistance (S. Rep. No. 404, pt. I, 89th Cong., 1st Sess. 77 (1965)) and included "all individuals who would, except for income and resources, be eligible for [categorical assistance] * * * and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services * * *." 42 U.S.C. (Supp. V) 1396a(a)(10)(C)(i).

The language and legislative history of Title XIX evidence an unmistakable congressional intent not to require the medically needy to reduce their level of maintenance income below their state's categorical assistance standard of need as a precondition to medicaid relief. Indeed, the purpose of assistance to the medically needy is to help the working poor *avoid* the necessity of living below a subsistence level because of heavy medical bills. As the Senate Finance Committee stated in recommending adoption of the "spend-down" provision in Title XIX,[8] which allows an in-

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[8] 42 U.S.C. (Supp. V) 1396a(a)(17) provides in part that a state plan must

> provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law * * *.

After all appropriate factors have been subtracted, an applicant's income is measured against the participating state's medically needy minimum income level. Those whose count-

dividual to qualify for medicaid coverage if the deduction of his incurred medical expenses would reduce his income to the medically needy level (S. Rep. No. 404, *supra*, at 79):

> In no event * * * may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

These concerns are implemented by 45 C.F.R. 248.3(c)(1)(ii), which requires state medicaid plans to set the minimum amount that the medically needy may retain for normal living expenses at a figure equal to or above the most liberal payment standard generally used in the state's categorical assistance programs.[9] Compliance with the Secretary's directive

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able income is below the medically needy level are automatically eligible for medicaid assistance. Those with countable income above the medically needy level must "spend-down" to establish eligibility, *i.e.*, they must incur medical expenses in an amount equal to their excess income. 45 C.F.R. 248.3(c)(2); 45 C.F.R. 248.4(b)(5). Any additional medical expenses are absorbed by medicaid.

[9] This regulation was initially published by the Secretary in the *Handbook of Public Assistance Administration* § D-4220(A)(1)(b) prior to its promulgation in 1969. The *Handbook* stated:

> The income levels for maintenance must be, as a minimum, at the level of the most liberal money payment standard used by the State, at any time on or after January 1, 1966, as a measure of financial eligibility in any categorical money payment program in the State.

thus assures that a state may not insist that a medically needy individual "spend-down" below the level which the state has deemed necessary for subsistence, and hence—in contravention of the express congressional assumption—become more needy than the categorically needy in order to receive aid under Title XIX.

2. The district court correctly concluded that the method adopted by New York for determining eligibility for and extent of medicaid assistance violates the federal regulation.[10] Those medically needy individuals in New York, such as respondents, whose actual shelter costs are within the AFDC maximum shelter allowance for the social services district in which they live but are above the average statewide shelter allowance for a family of comparable size, are required to "spend-down" below the level of support furnished persons through AFDC categorical assistance. This is the precise evil against which 45 C.F.R. 248.3(c)(1)(ii) is directed.

Respondents' case clearly illustrates the defect in the New York practice. Marion Aitchison and her daughter Janice receive a monthly income of $368.39, primarily from social security disability benefits (Pet. 8). Since respondents' income exceeds the $317 level of N.Y.S.S.L. 366(2)(a)(8), they must "spend-down" the overage, $51.39 per month, before the

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[10] Although the Secretary originally approved New York's medicaid plan, he has now advised the State that its average shelter cost provisions are not in compliance with 45 C.F.R. 248.3(c) and Title XIX of the Act. See App. A, *infra*.

New York medicaid program will defray the medical expenses occasioned by George Aitchison's nursing home care. If respondents were totally without income or resources, however, they would receive a monthly subsistence payment of $370 under New York's AFDC program (see p. 6, *supra*), in addition to full medicaid coverage under 42 U.S.C. (Supp. V) 1396a(a)(10)(A), and would accordingly retain more income.

None of the reasons offered by petitioner justifies this anomolous result. The phrase "generally used" in 45 C.F.R. 248.3(c)(1)(ii) cannot support the use of an artificial "average" shelter cost since, as the district court correctly observed (Pet. App. 12a), "New York's 'average ADC standard' is never used, let alone generally used, as the ADC payment standard." The more reasonable interpretation of that phrase is that a participating state is obliged only to set its medically needy eligibility level no lower than the highest categorical assistance payment that the state would make in otherwise similar cases, but without taking into consideration unusual special need items such as, *e.g.*, corrective shoes. See, *e.g.*, N.Y.S.S.L. 131-a(6).

Nor is there merit to petitioner's related contention (Pet. 21) that New York has no single AFDC standard of need and that, therefore, any reasonable minimum maintenance level that it selects for the medically needy would fulfill the requirements of 45 C.F.R. 248.3(c)(1)(ii). The State's AFDC payment standard consists of the basic flat grant plus the variable

component attributable to the applicant's *actual* shelter cost (up to a maximum based on locality). Although this of course produces different AFDC assistance payments in disparate cases, it does not follow that the State cannot fix a readily ascertainable payment standard except by resort to a statewide average. See Br. in Opp. 11-17; App. A, *infra*. By nonetheless adopting an average shelter cost, New York's plan is patently unreasonable because it necessarily withholds medicaid assistance from a substantial number of applicants until they become more needy than recipients of categorical assistance.

Finally, New York's use of an average shelter cost is not sanctioned by the approval given by this Court and the Secretary to flat grants on the basis of the consolidation of previously variable items (Pet. 16, 25-28). See *Rosado* v. *Wyman*, *supra*, 397 U.S. at 419. As the Court noted in *Shea* v. *Vialpando*, 416 U.S. 251, 265, n. 13, "*Rosado* * * * was in no sense intended as a blanket approval of the principle of averaging under AFDC programs without regard to what is being averaged." The departmental materials on which petitioner relies (Pet. App. 30a-43a) refer only to categorical aid programs such as AFDC, in which a limited flat-grant concept may be feasible, rather than to wholly different programs such as medicaid. But more importantly, petitioner's arguments are simply inapposite: federal medicaid regulations do not disallow reliance on averaging under all circumstances; rather, they require only that when a state uses actual costs in computing standards of

need for its categorical assistance programs, it must incorporate comparable standards in determining income eligibility for the medically needy, lest some medically needy individuals be forced to "spend-down" below the level determined necessary for subsistence.[11]

3. Although respondents contend (Br. in Opp. 11-17) that the problem of substantially disparate medicaid and categorical assistance levels is "virtually unique" to New York, the Secretary believes that a few other states may derive their medically needy eligibility standards by averaging certain variable items that are paid on an actual cost basis in the categorical assistance grant. In either event, the problem illustrated by this case is not extensive and can be handled administratively by the Secretary through negotiation with participating states or, if necessary, disapproval of state plans. See 42 U.S.C. 1396a(b).[12]

Furthermore, the decision of the district court is consistent with the holdings of other courts [13]—includ-

[11] As the letter from the Department's Acting Regional Commissioner (App. A, *infra*) indicates, the Secretary believes that income eligibility for the medically needy need not be determined on an individualized basis and that all that Title XIX requires is the establishment of firm, rational standards against which all individuals' eligibility may be tested and which fulfill the purposes of the Act.

[12] In May 1975, for example, the Secretary advised the Boston Regional Commissioner that a Connecticut plan to average shelter costs in determining eligibility would violate federal medicaid regulations. See App. B, *infra*.

[13] See *Dominguez* v. *Milliken*, CCH Medicare and Medicaid Guide ¶ 26,633 (W.D. Mich.); cf. *Schaak* v. *Schmidt*, 344 F. Supp. 99 (E.D. Wisc.); *Wilczynski* v. *Harder*, 323 F. Supp. 509 (D. Conn.); *Wong* v. *Brian*, CCH Medicare and Medicaid Guide ¶ 26,605 (Cal. Ct. App.).

ing a New York state court ruling that concerned the precise statute involved here. *Schlemowitz* v. *Lavine*, 75 Misc. 2d 529, 347 N.Y.S. 2d 133 (Sup. Ct.). In these circumstances, we believe that further review of this case is not required.

CONCLUSION

It is respectfully submitted that the petition for a writ of certiorari should be denied.

ROBERT H. BORK,
Solicitor General.

WILLIAM H. TAFT, IV,
General Counsel,

SARAH WILLIS WILCOX,
Attorney,

Department of Health,
Education, and Welfare.

SEPTEMBER 1976.

APPENDIX A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION II
FEDERAL BUILDING
26 Federal Plaza
New York, New York 10007

Social and Rehabilitation Service

Jul. 19, 1976

Mr. Philip L. Toia
Commissioner
New York State Department
of Social Services
1450 Western Avenue
Albany, New York 12243

Dear Mr. Toia:

After extensive consideration, we have concluded that the medically needy levels contained in your Title XIX plan raise serious questions of compliance with Federal requirements. This letter discusses the basis for our questions and the steps required to remedy the problem.

The federal regulations at 45 CFR 248.3 (c) provide, in part, that with respect to the medically needy:

> The income levels . . . must be, as a minimum, at the higher of the levels of the payment standard generally used as a measure of financial eligibility in the money payment programs, that is:

(A) In the case of families of three or more, at the level of the payment standard of the state plan approved under title IV-A generally applied;

(B) In the case of individuals, or families . . . of two persons, at the higher of:

(1) The payment standard . . . under title IV-A generally applied, or
(2) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind, and disabled) who are (or would be, except for income) eligible for benefits under title XIX;".

This regulation means in general that the lowest medically needy eligibility level must be at the highest cash welfare standard for the comparable family or individual. The intent of the regulation is twofold and reflects the statutory mandate of sections 1902 (a) (10) and 1902 (a) (17) of the Act. First, as provided in section 1902 (a) (10) of the Act, the medically needy, (if the state wants to cover that group), must include all those individuals who "but for income and resources" would be categorically needy Medicaid recipients. In most instances, the categorically needy are cash assistance recipients. Therefore, the medically needy standard must be such that people with income sufficient to bar them from cash assistance do not have to become "poorer" than cash recipients before becoming eligible for Medicaid. It follows that if the level is below the amount used

for cash assistance, a family might be required to "spend-down" to an amount lower than the payment to a welfare family without income.

Furthermore, section 1902 (a) (17) requires that eligibility must be based on "reasonable standards" comparable for all groups, (of different size) and such standards cannot otherwise vary with respect to income levels except for the medically needy and then only based on a limited number of rural-urban differences.

Your Aid to Families With Dependent Children program incorporates various shelter allowances—up to a maximum—in determining eligibility for, and amount of, cash assistance under that program. That is, financial eligibility is determined by measuring an individual or family's available income against a basic payment standard plus a money amount up to a maximum representing shelter costs. At this point, a separate schedule of maximums has been established for each Social Services District.

The key question is how these various shelter standards must be treated in setting a medically needy eligibility level. As we understand it, the medically needy levels now in effect reflect an average of shelter payments, plus the standard for basic needs for each group. However, this system resulted in a disadvantage to certain people whose shelter costs were above the average, yet lived in an area where the shelter maximum was higher than this average.

As a consequence, the U. S. District court, in Aitchison v. Berger, found the "averaging" method invalid.

We have considered carefully the possibility that eligibility for the medically needy be determined on a case-by-case basis, using the applicable shelter maximum and the rent actually paid. The Medicaid recipient would be expected to "spend down" to the individually determined figure. Such a system, however, would not only be costly in terms of administrative time and expense, but would be in conflict with the Act and Regulations, in that section 1902 (a) (17) of the Act and 45 CFR 248.3 contemplate a statewide simplified medically needy standard for groups of comparable size with the only exception being urban-rural variations.

We must conclude, therefore, that, given the present AFDC standard, compliance with Federal statute and Regulations could best be achieved by establishing a limited number of medically needy levels based on groupings of the shelter variations by Social Service District. The medically needy level for each group or cluster of Social Service Districts would be the basic payment standard, plus the *highest* shelter maximum in each cluster.

We recognize that such an action would materially increase medically needy levels at a point when you are confronted by serious fiscal restraints. However, this alternative would satisfy the requirements of the Act and the implementing Regulations.

Since the currently effective medically needy levels are contained in the approved New York Title XIX plan, we are now withdrawing our approval of that section of the State plan. The standards in question are contained in Attachment 2.6-A of the approved plan, submitted by Transmittal 74-2 and approved on December 30, 1974. If it is not possible for your agency to take corrective action, it will then be necessary for us to recommend to the Secretary that this section of the State plan be disapproved.

Our staff is of course available at any time to discuss the matter further.

Sincerely yours,

/s/ William Toby
WILLIAM TOBY
Acting Regional Commissioner

APPENDIX B

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Office of the Administrator

Date: May 29, 1975

TO : Mr. Neil Fallon
SRS Regional Commissioner
Region I—Boston

FROM : Administrator
Social and Rehabilitation Service

SUBJECT: Connecticut—Medicaid Eligibility—Medically Needy Income Levels
(Your memoranda of 6/18/74, 10/1/74 and 10/11/74)

This is in response to your memoranda requesting information on the extent to which a State may vary its medically needy income levels on the basis of urban-rural differentials in shelter costs.

a. Is the State required to establish more than one medically needy income level to reflect variations in shelter costs?

No. Per Section 1902(a)(17), in determining eligibility, a State must include reasonable standards which must be comparable for all groups. In determining reasonable standards

for the medically needy, the State is not required to reflect the variation in shelter costs between urban and rural areas.

b. How many income levels to reflect urban-rural variations in shelter costs may the State have?

A State may apply a variation based on an urban-rural distinction in shelter costs thus establishing two income levels. However, if a State can establish that more than two urban-rural variations in shelter costs exist, additional variations could be approved under the plan.

c. If a State has three variations in AFDC standards, but retains a single income level for the medically needy, how is the amount of single income level determined? That is, must the single income level be set at the highest amount paid under the AFDC program in any area of the State?

Since the AFDC shelter amount is as paid, up to a maximum, can the State use an averaging method, means or median, in determining the shelter costs that go into the standard?

If the State has in effect three approved variations in AFDC standards, and if the State wishes to establish one medically needy income level, the State must set its single medically needy income level at least at the highest of the three AFDC standards (conforming, of

course, to other regulations on the establishment of the medically needy level (45 CFR 248.3(c)(1)(i), (iii) and 248.4(b)(4)). In no case could the State use an averaging method to set its medically-needy level.

/s/ James S. Dwight, Jr.
JAMES S. DWIGHT, JR.

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